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ABSTRACT

This report of a 13-state conference on the needs of young children in the Appalachian region examines present conditions and changes over the past decade. The conference was organized around three central questions: (1) what are the needs of Appalachian children for healthy development? (2) how do existing child development programs meet these needs? and (3) what do Appalachian programs need in order to improve their delivery of services? Conference recommendations include: emphasis on early intervention, with recognition of family context and cultural background; development of manpower, including administrative manpower; greater utilization of public information resources to obtain financial support; development of information and referral systems; improvement of communication among programs and states; establishment of a network for legislative information; development of a data base on needs and services; and an increase in parent involvement. Included with the text are tables of data on health manpower, employment and per capita income for the region, as well as information on a variety of projects funded from several sources. Appendices include suggested fundraising and proposal writing procedures and a series of charts showing the distribution of health care personnel, nutrition services, and infant mortality rates in the Appalachian area. (BF)

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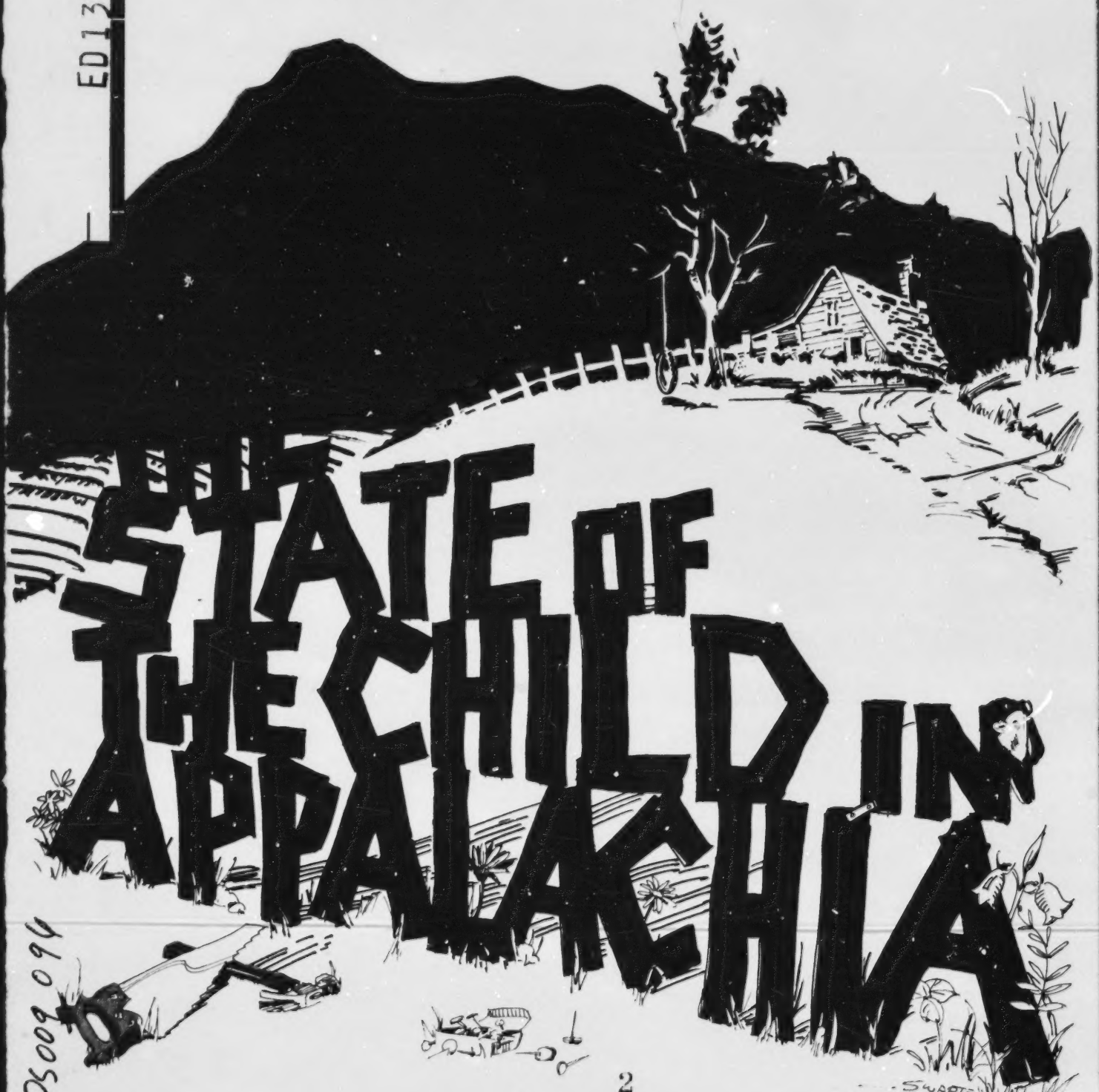

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The State of the Child in Appalachia: Report of a Conference

by Dana Friedman Tracy
Peggy Daly Pizzo

JANUARY, 1977

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Sponsored by the Appalachian
Child Care Conference Planning Committee,
Chairperson, Nancy Travis,
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Photo Credit: Lawrence Hughes

Donna Judkins and Robye Dunnivant working with students in the Decatur Public School System (Carver School).

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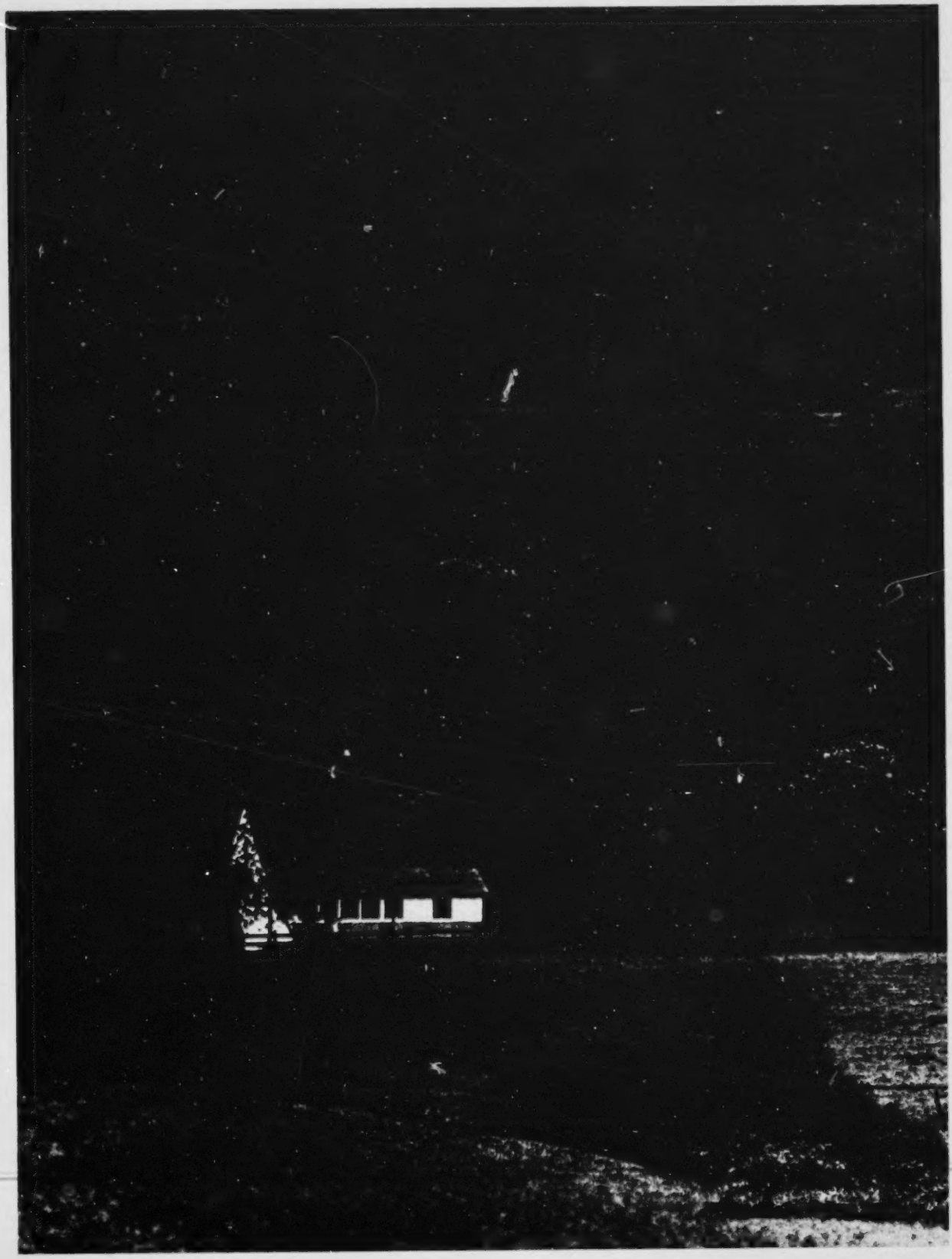

PREFACE

A CELEBRATION OF APPALACHIA

The "State of the Child in Appalachia" conference was in many ways a celebration. Readers of this report who are accustomed to thinking of Appalachian children in images of hollow-eyed waifs might startle at the word "celebration." But conference participants — who came from all walks of life — came not only to discuss the problems of the Mountain states, the severe poverty, the crushing needs that they so determinedly try to meet. They also came to celebrate the diversity of a region which extends from New York to Mississippi, the strengths of Appalachian families, the stubborn stamina of Appalachians and their special, advanced cultural achievements. And they came to celebrate the accomplishments of Appalachian child and family advocates — the babies born healthier than ever before, the decline in infant mortality, the blood of Appalachian children enriched and strengthened because of better nutrition, the rise in the numbers of children protected against dangerous diseases, and the thousands of parents who have entered the labor force in Appalachia because of child development services. Although there is much more to be done, surely it is clear now that it *can* be done. In 1966 there were doubters who called the odds insurmountable. Ten years later, in 1976, there are successes where there was once mainly doubt. And that is cause for celebration.

PLANNING THE CONFERENCE: PROCESS WAS IMPORTANT

WHY WAS THE CONFERENCE PLANNED?

During April 1976, over 431 child and family advocates came from 20 states to meet in Knoxville, Tennessee and share their knowledge about what is being done and what needs to be done for young children in Appalachia.

How did the idea originate for a State of the Child in Appalachia conference? It was an idea that had grown for years. A few committed child advocates had long envisioned what it could mean for Appalachian services if practitioners (the real experts in service delivery) had the opportunity to get away from their demanding work for just a few days and share informally their unique perspectives on what Appalachia is and what it might become. They felt that the pooling of knowledge about ways to deliver services and overcome barriers, so varied across the Region, would directly benefit Appalachian children.

The conference was convened by people who genuinely sought to learn what is the state of the child in Appalachia now. They were especially concerned in this bicentennial year, 1976. The group recognized that the "state of the child" had changed greatly in the last ten years and that there is a need to take a comprehensive look at this question. The last ten years have meant a large scale increase in public services to Appalachian children not only through ARC programs but through Head Start, Community Action, Title XX, Food Stamps and other public welfare programs. Conference planners wanted to know how much these efforts actually had accomplished and how much remained to be done.

Furthermore, they recognized that besides the relatively recent advent of publicly funded programs, church and voluntary programs have been deeply committed to Appalachian children for at least sixty years. Conference planners wanted to know the views of the "private sector" on the "state of the child" and how privately funded practitioners saw their institutions changing in response to newly voiced needs and newly created programs.

In addition, many of the programs that had been approved by the Appalachian Regional Commission for the full five years of funding permitted by law now find themselves in the final year of ARC funding. Further, since 1975, each state now receives a "single allocation" of ARC funds, i.e., no funds are set aside for child development, health, education, housing, water and sewer projects, etc. Each state now makes its own determination as to how much of its "single allocation" will be spent in Congressionally authorized program areas.

Since advocates of services to families must now compete with advocates of "brick and mortar" for a priority place in each state's plan for ARC funds, conference planners thought that both a conference and a conference report would be invaluable. Equipped with information about what is being done to help Appalachian children through *present* funding, as well as knowledge of what needs to be done, providers, parents, and community leaders concerned about children could tackle more effectively the job of educating the public about the significant successes in Appalachia and the need for other sources of public support. In this way, they could continue the successes which have been demonstrated through the pilot funding of the Appalachian Regional Commission.

And so, a 13 state meeting of concerned people — the first time such a meeting would be held — was determined to be the most effective way to air all these concerns and engage in a supportive exchange of helpful ideas.

WHO PLANNED THE CONFERENCE?

The actual conference was not planned by an established committee or organization — or even by a group which had conducted efforts around such matters as conference planning before. Nor was there considerable time or money available to plan this conference. Instead, because all concerned were committed to having a broad representation of advocates from different states and different agencies, the conference was planned by an ad-hoc group of persons intensely interested in (and busily working towards) a good future for Appalachian families.

Planning of the conference took place at the same time that funds were being sought. Consequently, all of the planning committee members were "donated" by their respective agencies. This meant that only those agencies with budgets for travel and staffing patterns that could tolerate the diversion of precious time from day-to-day service activities were able to send representatives to the planning committee.

The first planning meeting was held in December, 1975, and a planning committee developed.* Save the Children Federation hosted

*Please see Appendix 6 for list of planning committee and contributors.

the meeting at the Boone Tavern in Berea, Kentucky, where the conference objectives were discussed and shaped around a basic agenda.

The second planning session was held in Washington, D.C. January 27-28, 1976 so that it would coincide with a meeting of the State Child Development Directors from the 13 Appalachian states. It was at this meeting that the committee decided that the conference should be held in Knoxville, Tennessee, an Appalachian site convenient to an airport, and that it should function on a low cost budget, given the shortage of money for services.

A one day meeting was held near the Atlanta airport on March 17, 1976, to complete the basic agenda and to identify additional presentors. By mid April it became apparent that the size of the conference was going to exceed the original estimate of 200-250 people, so one last meeting was held at Howard Johnson's to finalize arrangements and to plan for the larger number of participants.

From the very first meeting, the conference was organized in a thoughtful and skillful manner. It was decided that participants should have the opportunity from the start to share their spirit and enthusiasm for their efforts as well as their knowledge and experiences. The first session would thus be an evening of music, folklore, and perceptions of life in Appalachia.

The committee felt that the following day should then be devoted to assessing the state of the Appalachian child, beginning with a keynote speaker who would introduce conferees to Appalachian culture and family life and then continuing with seminars on nutrition, health, child care, and other basic needs of Appalachian children and families. The afternoon was planned to focus on the current status of public and private children's programs other than ARC health and child development demonstrations. The state of ARC demonstration programs would be described during a series of workshops on the second full day, so that participants could learn about unique ways in which services are being delivered to Appalachian families. It was hoped that all of this information would result in a general session, on the final day, in which the group could identify issues of common concern and define strategies which would involve the full 13 states in the development of a better life for the children of Appalachia. Commitment and sharing typified the planning of the conference — and the conference itself.

We deeply hope that this report will continue this kind of involvement and sharing across the many miles of mountainous terrain that comprise Appalachia.

Interagency Child Care Center, Kingwood, West Virginia

We have decided to organize this report around three central questions that formed the bases of planning for the conference. **First, what do we know about what a young child, and particularly an Appalachian child, needs for healthy development? Secondly, what do we know about effective ways to deliver services that meet those needs? And third, what do Appalachian child development programs need to better deliver these services?**

This report draws upon the information that was exchanged at the conference, data collected by several major studies sponsored by the Appalachian Regional Commission on the experience of child development programs in Appalachia (see Appendix 1), and on personal communication with providers of child development services in the Appalachian area. The proceedings of the "State of the Child in Appalachia" conference however, will be the base from which we present information, statistics, descriptions of interesting programs, and ways in which friends of Appalachian families are generating increased resources for services.

Because the mountain supper symbolized the celebratory spirit of the conference and its orientation toward Appalachian culture, we would like to begin the report with an account of this very successful event.

THE CONFERENCE

MOUNTAIN SUPPER

As conference participants arrived, they could hear from outside the church the singing, clapping, and foot stomping of the Mountain Supper, the first conference "session." Appalachian advocates sat down to a delectable sampling of real "country" fried chicken, biscuits, green beans and other traditional foods.

After dinner, participants were entertained from the heart of the mountain culture with jacktales, preaching, and song. Mike Murphy, a State Representative from Tennessee, opened the entertainment portion of the evening by welcoming everyone. This was significant for conference participants because Mr. Murphy has for many years been instrumental in passing legislation that would help the children in Appalachia. It was most appropriate to have him share the evening with others for whom he has been working so hard, for so long.

A group of day care center teachers called the Knoxville Nursery Cornpickers, sang the children's songs they sing to their children everyday. Everyone joined in for a solid half hour of humorous and subtlely philosophic songs, reminders of why they had come and who they represented.

Loyal Jones, Chairman of Appalachia Studies from Berea College told a jacktale, familiar to those who have grown up in the hills, but new and different to those who had never before even heard the term "jacktale." Perhaps the highlight of the evening was the brief example of "mountain preaching" presented by Dr. Cratis Williams. He left the audience not only with an uplifted spirit but with insight and sympathy for a strongly held Appalachian tradition.

Bob Rickert, Chairman of the Special education Department at Tennessee Technological University, came with his guitar and sang some very beautiful folk ballads for the group. Darrin Douglas played on the Dulcimer some traditional Appalachian ballads learned from her grandmother, and accompanied the group as they sang "old favorites."

What is most important about these contributions is that all of these people are of a professional caliber, certainly worth payment for their talents — but instead they have all used their talents to serve the people and children of Appalachia, continuing to enrich the lives of the region's people and to carry on the traditions and beauty of a culture found only in the hearts of Appalachians. This committment to Appalachia's children and the spirit of respect for Appalachian culture characterized the entire conference.

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Interagency Child Care Center, Kingwood, West Virginia

QUESTION I

WHAT ARE THE NEEDS OF APPALACHIAN CHILDREN?

What are the needs of Appalachian children? What do we know and how do we know it? These questions formed the basis of the keynote address and workshops held during the first part of the conference.

KEYNOTE ADDRESS

A major source of information and inspiration was the keynote address of Dr. Cratis Williams of Appalachian State University in Boone, North Carolina. After receiving the key to the city of Knoxville, Dr. Williams focused his remarks on the values and history which have shaped families in the central Appalachian area. While dwelling on the central Appalachians, his speech helped clarify for the audience a picture of broader diversity among the families in the thirteen state expanse which encompasses Appalachia. It includes Indian children of the Seneca and Cherokee nations and non-Anglo Saxon white children whose parents have immigrated to the area to work in communities where mining or light industry exists. It also includes the Southern tier of Appalachia — Georgia, Alabama, Mississippi and the Carolinas — where many Black Appalachian people life. (The overall estimated percentage for Black Appalachians is seven percent.) There the people have drawn not only from the mountain tradition, but also from the rural Southern way of life and from their own Afro-American culture.* Each of these groups, along with the central Appalachian, have a special history and cherished set of values which must be understood and respected by human resource workers.

Dr. Williams spoke from two perspectives: "My own experience and what others say." He characterized himself as "100% Appalachian" and offered conference participants a vivid picture of Appalachian family life and ancestry as he has lived and studied them.

Appalachians have a fierce loyalty to one another and are able to identify themselves as a group, explained Dr. Williams, because of 1,500 years of protecting themselves. They originated from the hills of Ireland, where they were fleeing from the English and Scotch borders. When resettling in Northern Ireland after the religious clash in England during Oliver Cromwell's overthrow, they became expert drapers and linen workers. Local taxes then destroyed the linen industry and within 25 years the population had outgrown the capacity of the land. They became Presbyterian, learned the scriptures, and began establishing schools. When they came to America they brought with them the concept of the importance of school — their own school. They settled in the mountains while Indians still lived there. These people were highly educated, lovers of culture and Greek and Latin classics (hence the common Appalachian names, Homer and Virgil).

During the Civil War, Appalachians could not identify with other parts of the South. Since they were unable to develop a sense of "belonging" to the South, the Appalachians, whose isolated culture had been heightened by the geography of the mountains, became more separate and distinct — truly "a region apart." After the Civil War, Appalachians stayed with their rich mountain heritage and did not join the westward migration. The land, however, was not as rich as their heritage. It was not suited to farming or industrial development, as were other less mountainous areas. Land values plummeted, along with local tax bases. Although Appalachians wanted to build their own schools and educate their children with ideas brought from their Celtic heritage, they were prevented from doing so by shrinking incomes. This was also the time when the "feuding" reputation spread to the press. The families became a stereotyped oddity, characterized by their 16th century English, singing of old ballads, and telling of folk tales.

When the children began going to schools in the nearby communities, the teachers rejected 100 years of their heritage — their use of English, and their customs. Appalachian people became a withdrawn, shy group, living in Southern states where they were stereotyped as outsiders.

The child is the center of the Appalachian family. It is thought to be God's will to have children and they are accepted fatalistically. Infants receive the most attention. They are referred to as "lap children," cuddled and secured on the parents' laps. Affection is not bestowed upon older children as it is during their younger years. These children have the responsibility of caring for the younger ones and have carefully assigned chores to do for the household. They are punished for misdeeds until about age 12, after which time they are advised and given the opportunity to establish their own worth. Boys are expected to use their own judgment and have great freedom to determine their own course of action. Girls, on the

*In 1972, a Black Appalachian Commission was funded to identify and document the cultural differences and to see that the interests of Black people were represented in the overall planning and implementation of services.

other hand are seriously protected once they mature physically. Marriage at an early age is still common and strong feelings against divorce is the prevailing sentiment, although these attitudes seem to be changing.

With the twentieth century discovery of coal and the placement of textile mills in neighboring valleys, Appalachian customs began to change. Families that once depended on self-contained livelihoods now had to depend on outside industries. A strong sense of family, cultural pride, and pampering of young children however still characterize Appalachian families and should be remembered by those studying, servicing or educating the children of Appalachia.

After the keynote session, conference participants divided into smaller workshops to study specific needs of Appalachian children. The major task of the morning workshops was to assess how much is known about the state of the child in Appalachia. Conference participants shared with each other their high levels of awareness and sensitivity towards the specific needs in their own individual areas. One realization, however, was that no one has yet collected enough information to substantiate the *scope* of the needs of *all* Appalachian children — both those being served and those not yet reached. Probably one of the significant outcomes of the conference was a greater awareness of the need to gather and use wisely such information.

The information presented in this section is garnered from all the available data offered in the workshops, data based primarily on years of first hand experience serving Appalachian families, on surveys done by the State Interagency Councils, resource and community developers, and on university study. Additionally, we have added where we can, data gleaned from ARC contracted reports on child development in the 13 Appalachian states or other publications with which we are familiar. (See Appendix 4.)

WHAT CHILDREN NEED: A GOOD BEGINNING

If we begin our discussion of the needs of Appalachian children with the fact of birth, we can present here a fact sheet distributed at the conference by Barbara Clay of West Virginia. (See chart, page 11, 1973-74 Live Birth Data.) A look at this chart reveals that in seven Appalachian states, more than 25% of all live births are born to women under 19 years of age.

These facts about the birth experience need to be examined in the context of what medical research has shown about a good beginning for babies. Many conference presentors summarized the findings of the medical literature in this regard. We know that most of all, babies need healthy, well-nourished mothers who have received good prenatal care. Although broad statistics about health conditions in Appalachia are rather scarce, we were able to locate the following facts within a draft of the final report of ARC's Health and Child Development Subcommittee:

In Appalachia:

—Disease rates are increasing generally.

—Incidence of hepatitis is increasing in rural areas.

—Streptococcus is increasing.

—These tend to be "public health" rather than personal health problems. They are symptoms of environmental factors such as unsafe water supplies and inadequate sewage and solid waste treatment.

—Tuberculosis, virtually eliminated in the U.S. as a whole, is still a major health problem in the Appalachian region.

—A pattern of significantly higher incidence for most disease exists in Central Appalachia.

—Fifty percent of all children in Central Appalachia are estimated to be infected with intestinal parasites.

—General health indices for Appalachia continue to be well below the U.S. averages.

Along with general health care facts, the statistics regarding prenatal care in Appalachia are also difficult to locate. However, the Tennessee Department of Public Health has documented that in 1972, between 20-25% of all live babies were born to women under twenty, and that the percentage of women receiving no prenatal care in the first trimester ranged from a "low" of 30% in some counties to a "high" of 60% in other counties. Over 5% of all live births in most Tennessee counties are babies with low birth weight (under 2,500 grams or 5 pounds). In some Appalachian counties, the percentage of live babies with low birthweight ranged as high as 10-15%.

Across Appalachia, access to good prenatal care is threatened by a continuing shortage of qualified personnel. The September 1974 draft report of the ARC Health and Child Development Subcommittee offered the chart on page 12 using statistics compiled with the help of the National Institutes of Health.

The medical literature has demonstrated that babies born to mothers (in particular teenage mothers) who have been malnourished or who

1973-74 LIVE BIRTH DATA FOR APPALACHIAN STATES

STATE	TOTAL BIRTHS IN STATE		BIRTHS TO WOMEN 15 and under		BIRTHS TO WOMEN 16 - 19		% OF TOTAL BIRTHS 16 - 19		% OF TOTAL BIRTHS 15 and under	
	1973	1974	1973	1974	1973	1974	1973	1974	1973	1974
Alabama	59,524	59,451	445	424	15,572	15,249	.7	.7	26.2	25.6
Georgia	83,349	83,291	773	702	21,846	20,493	.9	.8	25.6	24.6
Kentucky	53,618	53,443	244	248	13,231	13,037	.5	.5	24.7	24.4
Maryland	53,716	53,470	252	262	10,065	9,616	.5	.5	18.7	18.0
Mississippi	44,590	44,122	455	478	12,470	12,442	1.0	1.1	28.0	28.2
New York	238,861	239,504	703	639	31,980	31,691	.3	.3	13.4	13.2
North Carolina	85,727	84,244	498	511	21,807	20,765	.6	.6	25.4	24.6
Ohio	161,064	160,609	584	558	30,894	30,784	.4	.3	19.2	19.2
Pennsylvania	153,371	151,439	471	413	25,806	25,531	.3	.3	16.8	16.9
South Carolina	48,987	48,554	322	329	12,274	11,965	.7	.7	25.1	24.6
Tennessee	64,485	64,265	462	437	16,338	15,946	.7	.7	25.3	24.8
Virginia	71,931	71,091	294	324	14,599	14,043	.4	.5	20.3	19.8
West Virginia	27,559	27,878	60	90	6,397	6,330	.2	.3	23.2	22.7

Data provided by the National Center for Health Statistics, Division of Vital Statistics

HEALTH MANPOWER DATA

	U.S. Average/Total	Appalachian Region Total	Appalachian Subregion Totals		
			Northern	Central	Southern
Physicians/100,000 pop.:	149	98	106	66	93
# MD's	5	2	4	1	1
# OD's	154	100	110	67	94
Total Physicians	53	40	48	23	32
Dentists/100,000					
Nurses:	295	284	396	109	167
# RN's/100,000 pop.	120	139	164	94	114
# LPN's/100,000	415	423	560	203	281
Total Nurses/100,000	121.1	37.3	45.0	25.3	24.8
# RN/100 Hospital beds	49.2	18.3	18.6	21.7	17.0
# LPN/100 Hospital beds	170.3	55.6	63.6	46.9	41.8
Total Nurses/100 Hospital beds	18.070	1,357	849	103	405
Total Optometrists	106,606	7,805	4,658	488	2,659
Total Pharmacists	8,342	484	417	9	58
Total Podiatrists	25,743	1,558	920	89	549
Total Veterinarians	5,999	610	278	87	245
Number General Hospitals (Total)	153	135	169	77	117
(Number Beds/Hospital)	453	452	484	384	425
(Number Beds/100,000 pop.)	1,213	105	60	7	38
Number Other Hospitals					

have received poor prenatal care, are at a higher risk of prematurity, low birthweight, birth defects, mental retardation, and infant mortality.

It is not surprising then, as Dr. William Castor explained in the workshop on Nutrition, that in 1973, the Appalachian Region had a 6% higher infant mortality rate than the entire U.S. This figure of 6% represents a *decrease* in infant mortality since the inception of the Appalachian Child Development program. In 1963, infant mortality in Appalachia was 11% higher than the rate then existing in the entire U.S. And it must be borne in mind that the "better" infant mortality rates in the entire U.S. are in no way achievements to be proud of.

> America, the richest and most powerful country in the world, stands 14th among the nations in combating infant mortality; even East Germany does better. Moreover, our ranking has dropped steadily in recent decades.[1]

A 1973 National Academy of Sciences study of infant mortality in New York showed that 92% of the variation in infant death rates could be explained by low birthweight. In addition 97% of the variation in low birthweight could be attributed to the fraction of mothers who received little or no prenatal care.[2]

A major cause of low birthweight is malnutrition during pregnancy.[3] Furthermore, premature low birthweight infants have a higher rate of later malnutrition and of battering.[4]

All of these risks are accentuated in Appalachia. According to Dr. Castor, seven of the more southern Appalachian states, (North Carolina, South Carolina, Georgia, Tennessee, Kentucky, Mississippi, and Alabama) have so many infant deaths that they are, along with other states in the American poverty belt, primarily responsible for the high percentage of infant deaths reflected in the overall American rates. Reducing the numbers of infant deaths in Appalachia could substantially improve America's standing in the world community.

Dr. Castor further explained that in the states of North Carolina, South Carolina and Georgia, where a high black population exists, most of the infant deaths are caused by high blood pressure — a condition closely related to improper prenatal care.

Dr. Castor asserted that the poverty cycle could be broken in Appalachia if we take the responsibility of properly feeding mothers and children for their first two years of life. "High protein — meat, milk and eggs — make the difference," he said. He mentioned three requirements for the fulfillment of our "genetic destiny": 1) adequate nutrition, including a lot of protein; 2) avoidance of early stress, which reduces the incidence of high blood pressure and of infections; and 3) growth in a stimulating environment. As the reader can surmise, this workshop generated a great deal of discussion and praise from conference participants.

Other workshop leaders placed particular emphasis on other needs for a healthy beginning. Psychological readiness of the parents as well as preparation for birth and parenting are very important. In the case of very young parents, this kind of readiness may be negligible. The need for family planning at a very young age is critical, and many workshop leaders discussed the difficulties involved in extending family planning services in relationship to Dr. Cratis Willaims' perspectives on Appalachian family culture, with its tendency towards rejection of contraception and/or abortion and the stress on protection of the young teenage girl from sexual matters. In addition, workshop leaders in the School-Age Parents session discussed the problems created when local communities preferred to deny the existence of teenage pregnancy because of the opposition to teenage sexuality. Some communities express the fear that programs for school-age parents will encourage promiscuity. School systems in particular may neglect to refer adolescent parents to appropriate services. Ms. Patricia Byler, in describing the Adolescent Parent Program in West Virginia explained that in the seven rural counties they service, almost 50% of the adolescents referred to them had dropped out of school before they were reached. The implications for the future educational achievement and income producing potential of adolescent parents who leave school are obvious.

In addition, there is a special need for attention to young teenage fathers. Ms. Byler explained that in her programs, ⅔ of the young mothers were married by the time the infant was born. She has observed a great need for involvement of fathers in the labor and delivery process as well as in General Equivalency Diploma programs, and job counseling and referrals.

The need for a healthy beginning, of course, does not end in infancy. Well child care is a critical

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[1]Urie Bronfenbrenner, "Who Cares for America's Children," in *The Family: Can It Be Saved?*, ed. by Brazelton and Vaughn (Chicago: Year Book Medical Publishers, Inc., 1976).

[2]D.S. Kessner, *et al., Infant Death: An Analysis by Maternal Risk and Health Care* (Washington, D.C.: Institute of Medicine, National Academy of Sciences, 1973).

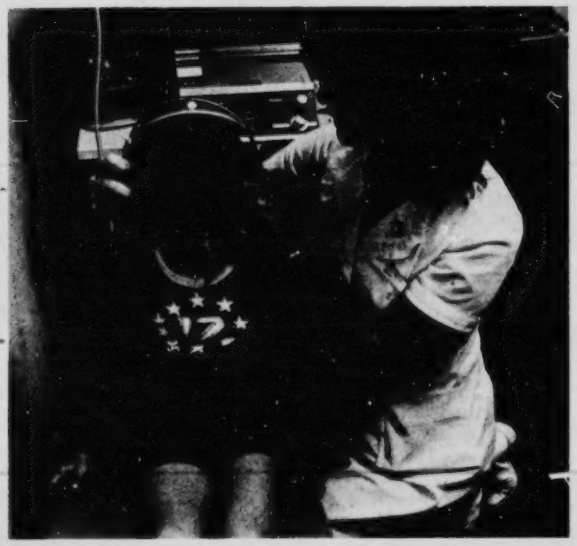
[3]*America's Children 1976: A Bicentennial Assessment* (Washington, D.C.: NCOCY, 1976).

[4]Marshall Klaus, commentary in *The Family: Can It Be Saved?*, ed. by Brazelton and Vaughn (Chicago: Year Book Medical Publishers, Inc., 1976).

need in the first few years of life. Immunization against polio, diptheria, tetanus, whooping cough and measles, for example, are basic ingredients of well baby check-ups. Well child care can aid in the early identification of developmental problems — problems which if caught early enough might be minimized before death or permanent damage occurs. An August 1975 report of Appalachia child development programs prepared by representatives from 10 Appalachian states (see Appendix 4) described a medical screening program in Mississippi which uncovered 92 cases of sickle cell anemia or sickle cell trait. Since these are conditions which can lead to frequent and painful hospitalizations, expensive medical treatment, transmission of the condition to future generations and possible death, and since these conditions can be greatly minimized if detected early enough,[5] the need for and benefits of such screening, particularly in Black Appalachia, are especially critical. The same might be said for dental disease, another condition which if detected early can be prevented from developing into painful, difficult to treat, expensive diseases. Dr. Jack Basman, in the workshop on Medical and Dental Services explained that 95% of the children seen in the West Virginia Children and Youth Project (serving children age 0-12) needed dental care.

In 1960, fifty cents (50¢) out of each health dollar was allotted to children, who comprise forty percent (40%) of the population and one hundred percent (100%) of the future. In contrast,the federal health budget now allocates ten cents (10¢) out of each dollar for children.

[5]Frederick North, "Screening in Child Health Care: Where Are We Now and Where Are We Going?", *Pediatrics*, Vol. 54, No. 5 (November, 1974).



THE NEED FOR STRENGTHENING FAMILIES TO HELP CHILDREN DEVELOP THEIR FULL POTENTIAL

There was much discussion at the Conference of the mental health and child development support needs of Appalachian families. Picking up on Dr. William's discussion of the unique characteristics of Appalachian families, presenters in the Mental Health workshop discussed the internal and external barriers to mental health in Appalachia. Internal barriers are related to the geographical isolation of families in the mountains, sometimes even separated from contact with other families. The strong self-reliance which developed in Appalachia sometimes contributes further to this isolation. Frequently the isolation of Appalachian families is expressed in Xenophobia, the love of one's own area to the exclusion and active dislike of involvement with anything from the outside. Dominant influences of "hell and damnation" religious services coupled with the very real economic suffering of the area contribute to a view of the outside world as harsh, cruel and dangerous. An emphasis on fatalism and conservative traditionalism which sometimes find roots in Appalachia religious and social culture further contribute to the resistance to change.

Schools too have a poor record of maintaining students beyond elementary or junior high school. School phobia may contribute to this, but so does the contempt for Appalachian folkways described by Dr. Williams. Lack of education perpetuates the poverty cycle and its resulting isolation. The cycles of coal industry prosperity and depression result in instability of employment opportunities. This also causes an outmigration to other areas and the subsequent breakdown of the extended family as aunts, uncles, cousins leave in search of jobs. With that breakdown, further sources of financial and emotional support are cut off from families with young children. The National Institute of Mental Health estimates that approximately 2 to 4 percent of the American population suffers from depression. In Appalachia, particularly in the coalfields, the problem has been estimated at as much as 50 percent.[6] A study by Cornell University of the mental health of miners and their families reported that as many as 80 percent of primary-care visits were for problems induced by anxiety.[7]

[6]Victor B. Ficker and Herbert S. Graves, "Deprivation in America," quoting Peter Schrag (Beverly Hills, California: Glencoe Press, 1971), p. 41.

[7]Bert Swift, Robert Decker, and Mike McKeown, "Mental Health in Appalachia: An Emerging Problem," in *Appalachia*, Vol. 9, No. 2, October-November 1975, p. 40.

"In both the ARC-funded primary care program and the child development program, over one-half of operating projects include mental health services as part of the service system, although there are relatively few projects with a primary thrust in mental health. At the present time, about 6 percent of ARC program expenditures in health are for programs concerned exclusively with mental health. A notable exception is West Virginia, where ARC is assisting the State Department of Mental Health to work with a variety of community agencies to develop preventive mental health services for children."[8]

These are problems which threaten the lives of families in poverty all across the United States. While low income populations in all areas, however, share many of the same problems, we do a disservice by "lumping the poor all together psychologically on the basis of their common lack of income."[9]

Appalachian families are unique. They have strengths as well as weaknesses. The critical need is for family support services — and not necessarily just mental health professionals — which reach out energetically and consistently to families suspicious of them; to isolated mothers with practical guidance and support of their child rearing tasks; to school personnel with support teams of specialists. There is a need also for an increase in personnel skilled in psychometrics, particularly in the area of language development. Chad Jackson, a social worker supervising the mental health program in the Cumberland Valley District of Kentucky explained that they have a limited number of psychologists to serve eight counties. In addition, time consuming travel allows fewer families to be served. The instability of funding for community mental health centers contributes to the lack of services.

These factors are reflected in child-rearing patterns which sometimes involve young children in frightening religious services and often prompt parents to use fear to instill obedience. Children then absorb the fatalism and fears of their families. In addition, the pattern of child-rearing has undergone a change from patriarchal to matriarchal and the mother now assumes most of the responsibility for the care of the children. Presentors in this workshop underscored Dr. Williams' observation that infants are showered with attention and affection to such an extent that older children tend to be neglected. This concentration on the infant also fosters an extreme dependence on the mother. The anxiety felt by children who are more neglected as they grow older or as school separates them from their mothers is a deep rooted problem among Appalachian children, frequently resulting in school phobia.

External barriers to mental health can be seen primarily in the economic system, the school and in family support services themselves. In some areas the dependence on one unstable industry (coal) has resulted in high unemployment, a sense of futility and a fatalistic acceptance of the inevitability of poverty.

THE NEED FOR ECONOMIC DEVELOPMENT

Although poverty continues to stalk Appalachia, the economic vitality of the Appalachian Region has improved in the last 10 years. Significant changes have taken place in population, job and income growth.

Population Growth

One of the most striking changes in Appalachia has been a reversal of its population tide: the Region is no longer losing population every year. For several decades, outmigration — especially of young people — had been heavy, largely because of the Region's lack of job opportunities. In the early 60's, Appalachia was losing about 122,000 inhabitants every year; this dropped to about 90,000 in the late 60's. Then, at the beginning of the 70's, the trend reversed; over the last five years, there has been an average annual inmigration of close to 60,000 persons.[10]

> In the 10 year period since ARC's inception, the Appalachian population increased 5% while the national population gained 10%. In the first 5 year period 1965-1970 however, population growth in Appalachia was at only 1/6 the national rate (0.85% compared to 51%). From 1970-1975 Appalachia's people increased nearly as rapidly as the nation's rate. "If this latter trend continues, the Region will have 19.7 million inhabitants in 1980."[11]

The mainsprings of population growth are based on 3 types of factors:

—economic growth associated with increasing employment.

—amenity growth: a return to the hills of

[8]"Mental Health in Appalachia: An Emerging Problem," in *Appalachia*, Vol. 9, No. [illegible] 38.

[9]Robert Coles, Fo[illegible] to *Appalachia's Children*, ed. by David Loof. (This book was also used as source material in writing this section.)

[10]Annual Report of the Appalachian Regional Commission, 1975, p. 1.

[11]Annual Report of the Appalachian Regional Commission, 1975, p. 11

people from the increasingly accessible, densely populated lowlands on 3 sides of the Region to retirement, recreation and second home developments, and an urban-to-rural movement of people seeking a simpler life style.

—a counter movement out of the principal industrial centers (chiefly in the North) as a result of their higher unemployment, housing shortages and higher living costs in the current economic recession.[12]

Northern Appalachia had by far the lowest growth (1.4%) and 20% of the Region's population increase. Central Appalachia, with just under 10% of the Region's population, accounted for 15% of its growth (a growth of 6.9%). Southern Appalachia had the greatest amount of increase (65% of the regional total) and the highest growth rate (nearly 7%).

Job Growth

Between 1965 and 1973, Appalachia gained more than one million jobs in major industrial group employment. Although its rate of growth was not quite so large as that in the nation as a whole, the Appalachian economy is showing signs of expansion into a variety of new industrial activities as well as growth in its traditional industrial base. (See chart p. 16)

Unfortunately, these gains have not been evenly distributed over the Region, nor have the successes of certain industries been immune to problems facing the nation. The Northern Appalachian states, for instance, were hit hard by the recession and their major industry, manufacturing, greatly suffered. This industry, while prevalent in Southern Appalachia, is newer and capable of resilience. While economic conditions in Central Appalachia are critical, they were hurt the least by the recession due in large part to the energy crisis and the increased demand for their primary industry, coal, as well as their reliance on other local markets rather than on the national market. A greater variety of industries are now looking to Appalachia as a base for new firms and an expansion of nonindustrial or social service jobs developed through manpower training. The creation of these jobs means reduced unemployment and increased incomes as well as a change in the very people and land of Appalachia. The life style, an individual's self-concept and his potential, community identities, and the mountains, the forests, and the streams can all change with the coming of economic growth and increased opportunity. The flavor and character of Appalachian life cannot be lost in the search for jobs.

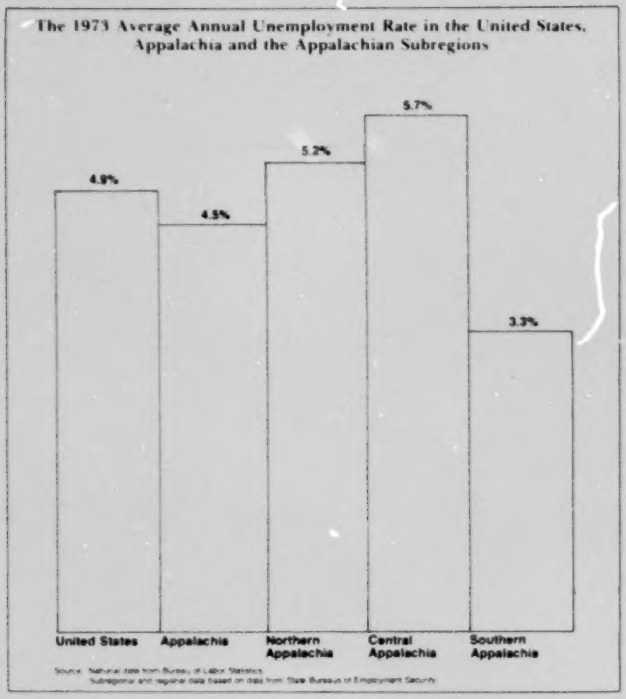
[12] *Ibid*, p. 12

EMPLOYMENT**

(in thousands)

	1965	1973	Change
Appalachian Region			
Manufacturing	1,861	2,109	+13%
Trade	853	1,141	+34%
Services	497	745	+50%
Region Total	**3,933**	**4,942**	**+26%**
Nation			
Manufacturing			+12%
Trade			+34%
Services			+53%
Total			**+28%**

**County Business Patterns* data—includes about 76% of U.S. paid employment.



Income Growth

Appalachia has long been characterized as one of the poorest areas of the nation. Yet between 1960 and 1970 the Region experienced a 40% decline in the number of people with incomes below the poverty level, while the national figures for the same period showed only a 30% decline.

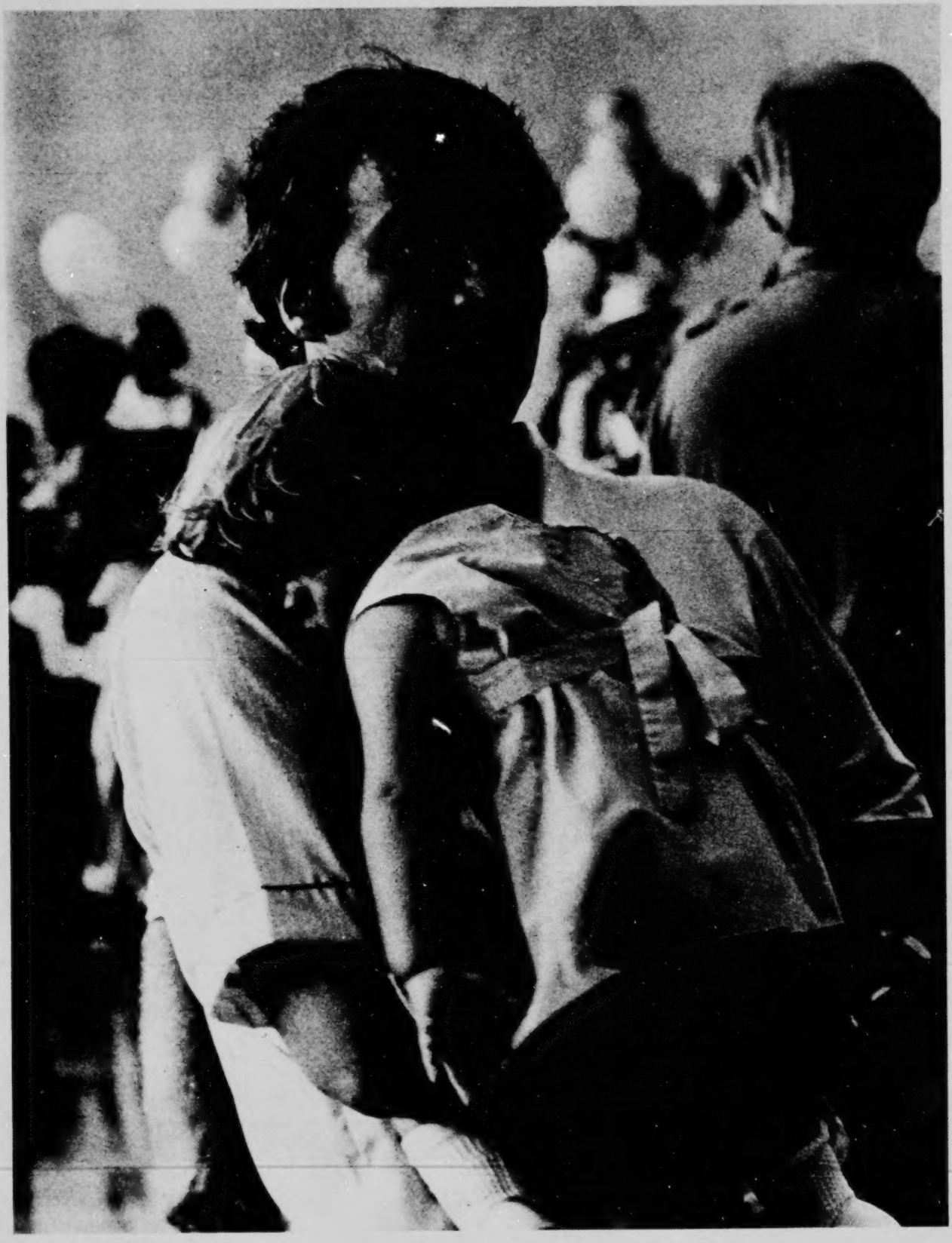
Another indication of both the continued need *and* of recent improvement in the economic health of the Region has been Appalachia's per capita income: it has risen since 1965, both absolutely and relative to the national average. It increased from $2,180 in 1965 to $4,110 in 1973 (the most recent year for which figures are available) — a rise of 89%. In comparison, national per capita income rose by 81% over this period. The Region's per capita income therefore climbed from 78% of the national average in 1965 to 81% in 1973.

It is important to realize that the continued economic growth of the Region depends on local, state and Regional action as well as federal policies. Child development programs play an important role in meeting the needs of Appalachia for greater income. It is therefore fitting to look now to the *programs* that have been created from such policies at all levels to see how they attempt to meet the social and economic needs of Appalachian families and children.

Per Capita Income in the United States, Appalachia and the Appalachian Subregions 1965 and 1973*

	1965		1973		1965-1973
	Per Capita Income	Percent of U.S. Average	Per Capita Income	Percent of U.S. Average	Percent Change
United States	$2,780	100%	$5,040	100%	+81%
Appalachia	2,180	78	4,110	81	+89
Northern Appalachia	2,410	87	4,400	87	+82
Central Appalachia	1,450	52	3,120	62	+115
Southern Appalachia	2,030	73	3,960	79	+95

*Per capita income data obtained from Bureau of Economic Analysis. All per capita income figures rounded to nearest $10. Percents rounded to nearest whole percent. All calculations performed on unrounded data.



QUESTION II

HOW DO CHILD DEVELOPMENT PROGRAMS MEET THESE NEEDS?

High protein foods . . . self-help canning programs . . . helicopters for acutely ill "premies" . . . family day care systems . . . health educators in preschool programs . . . home visitors who hike up mountains to counsel mothers . . .

These were some of the ideas discussed in response to the second major question addressed by the "State of the Child in Appalachia" conference: **How are health and child development programs attempting to meet the needs of Appalachian children?** Many of the workshops in both the morning and afternoon sessions of the second full day provided an opportunity for practitioners working to meet the needs of Appalachian children to share the methods they have used — both successfully and unsuccessfully.

Health and child development programs in Appalachia share three key features in particular: innovation, linkages, and a mixture of public and private resources. In our experiences as child advocates examining programs from a national perspective, these are features which are much more characteristic of Appalachia than of the country as a whole. In fact, nowhere else in the country have we seen such a concerted regional picture of innovation and linkages that meet children's needs. There is *much* that other programs in other parts of the United States can learn from looking at health and child development planning and programs in the 13 Appalachian states.

The *innovation* of Appalachian programs is an expression of determination to overcome the physical and economic barriers to the delivery of services in the Appalachian region. One such barrier is distance. In describing her agency's effort to reach school age parents at home in West Virginia, one conference participant said:

> A lot of our families you can't even reach by car. You have to park the car and walk across the bridge and then hike up the mountain for a mile.

But those who care about children and families in Appalachia have been "putting on their hiking boots" for years — both literally and figuratively. When distance impedes the ability of Appalachian families and practitioners to come to services, services are brought to them through the use of mobile vans, microwave T.V. programs, helicopter transport of sick infants, and decentralization of clinics and child care programs so that many small units function close to families rather than one large central program existing in a distant city.

Another barrier is personnel, particularly in the field of health. There is, as previously discussed, a terrible shortage of qualified medical personnel in Appalachia.

Appalachian practitioners have responded with innovative ways of developing personnel: the training and use fo physician extenders, the midwifery programs in Tennessee, Pennsylvania and other states, the advocacy for the use of nurse practitioners in health care delivery, and the training of local residents to become staff in child development programs.

Perhaps as a function of barriers like these and almost certainly as a result of a conceptual push towards coordination from the Appalachian Regional Commission, there seems to be a great deal of emphasis on linkages. Child care programs are linked to health and nutrition services for the *entire* family. Sometimes through enormously complex interweaving of funds, health programs manage to provide a wide array of nutritional, dental and comprehensive health care services for families.

> To promote a more comprehensive and integrated system of delivery at the local level, it was very important for Appalachian Child Development Demonstrations to concentrate on the issues which would build the capacity of state government and local units to plan and coordinate child development programs. This was the element of the Appalachian Demonstrations, which was most unique in terms of long range growth of child care in this country. It is an issue which has not always been fully appreciated by people at the local level. Whereas most "demonstrations" tend to study whether one method of intervention with children is more effective than another (e.g., open education curriculum vs. cognitively oriented curriculum) the Appalachian Demonstrations were frequently designed to determine which system of delivery using which agencies would most effectively serve large segments of a community. At the local level such experiments have appeared extravagent and at the expense of direct services. However, it is important to note that the Appalachian Demonstrations are the only place in this country where wide scale experimentation on delivery system issues has been authorized and despite identifiable cases of cost inefficiency or ineffective plan-

ning, such experimentation is a must if the country is to get full benefit from programs it has already authorized, let alone future programs of child development.[13]

The principal way that health and child development services are linked together in Appalachia is through the single entry point approach.

> In a single entry delivery mechanism, if a potential client enters the services network at any point, all of the services which exist throughout the system can be made available to him/her, either directly or through an established referral system.
>
> The single entry delivery mechanisms now in place for children's services involve greatly expanded integrated networks of public and private agencies and practitioners. The foci of these networks vary, as do the entry points, ranging from center-based day care to coordinated information and referral systems to comprehensive single agencies. The impetus provided by Appalachian Child Development Programs has been a major catalyst in the development of these networks.[14]

And the cornerstone of the single entry approach is planning and coordination. Although difficult and time-consuming and not *always* successful, planning and coordination make it easier for families to come into contact with comprehensive services. The Kirschner Report[15] concluded that the single entry approach, because it results in better planning and coordination among agencies servicing a variety of specialized human needs, is ultimately less expensive and at the same time eliminates overlap, competition among agencies, and omissions. One of the key features of planning and coordination in ARC demonstration areas is the local development district (LDD) (sometimes called area development district — ADD -- or area development planning commission) which is often a multi-county unit set up to improve communication between local citizens and their state governments about the human needs in their local communities. Conference participants were concerned about ways to make better use of their ADD's to express what the needs of local families are and to develop better linkages with local agencies.

Another feature of child development planning and coordination in Appalachia, at the state level, are the State Interagency Councils, comprised of key agencies and individuals responsible for children's programs. The Kirschner Report describes their responsibilities as:

> . . . the assessment of need, development of a comprehensive plan to meet identified needs and coordination of the full range of needed services including child welfare, nutrition, special education, health and day care.

The Report also goes on to describe the "ripple effect" of the ARC mandate for Interagency Councils for non-Appalachian areas of many states: "In most cases, this effort (the Interagency Council mandate) although on behalf of the Appalachian areas of the individual states, has had a direct and beneficial effort on the provision of children's services statewide."[16]

All this emphasis on planning and coordination has had other benefits as well. As the Child Development Report from the 13 states concluded:

> Whether planning and coordination occurs at the state, sub-state regional or local level, it is clear that ARC funds have stimulated the creation or substantial improvement of mechanisms for the delivery of services to young children and their families. There is, in fact, evidence that the child development programs have been instrumental in causing state and local governments to examine seriously the way human services are being delivered generally and to develop more responsive methods of addressing human needs.

Agency Diversity

One of the results of extensive planning and coordination has been the unique combination of private and public involvement of non-ARC supported agencies in targeting services to Appalachian children and families. Many such agencies were represented at the conference. They, too, were interested in sharing their observations about the changing needs of Appalachian families and the problems and accomplishments their institutions have observed. For this purpose the

[13]Joseph Perreault and Rod Hartzler, "Background Paper for Consideration of Kentucky's Options in Planning and Use of ARC Child Development Funds," unpublished paper.

[14]Appalachian Regional Commission, *Child Development: A Report by the Appalachian States* (Washington, D.C.: Appalachian Regional Commission, August 1975), pp. 33-34.

[15]Kirschner Associates, Inc. *Assessment of the Health and Child Development Program of the Appalachian Regional Commission*, July 1975. (In the following pages this publication will be referred to as the Kirschner Report.)

[16]The Kirschner Report, p. 4.

Wednesday afternoon session was devoted to a series of presentations by representatives of such groups. Some of the highlights of that session included:

The Commission on Religion in Appalachia

CORA is an organization which coordinates the Appalachian work of 18 separate denominations. It is organized into three divisions which parallel the prophetic, the pastoral and the service functions of the church. Through an Appalachian Development Projects Committee, it seeks to provide funds to local communities designed to achieve one of four goals: 1) meeting basic human needs; 2) building a community; 3) contributing to institutional and systematic change; and 4) contributing to self determination and empowerment of people. In addition to the work that individual church groups do in Appalachia, CORA is able to contribute $500,000 a year to community self-help efforts. (Contact John McBride)

Save the Children Federation

Save the Children Federation began in 1932 and has had a program in Appalachia ever since. Currently, Save the Children Federation is supporting projects in five states: West Virginia, Kentucky, Tennessee, Georgia and Mississippi. In Kentucky, Save the Children Federation supports a self-help center which calls upon Appalachian talents in an income-producing craft cooperative. In addition, its American Indian program works with the Cherokee nation in North Carolina and the Choctaw nation in Mississippi. Save the Children Federation programs stress looking at the child within the context of his family and community and all require participation of parents in deciding appropriate care for the child. (Contact Mr. Charles Wesley, see Appendix 8.)

Federation of Community Controlled Centers of Alabama for Child Care

FOCAL was begun in 1972 by a group of parents and community leaders who were concerned about the need of Black children to have an effective preschool experience and by the need for appropriate child care for parents seeking employment. FOCAL currently has a membership of 67 community controlled child care centers and 500 individual members. FOCAL has two full time staff who provide technical assistance, training and advocacy. As the program has developed it has moved from a concern with child care to even broader areas of assisting parents achieve community goals. It was also pointed out that similar federations have been started in Georgia, Mississippi, North Carolina and South Carolina.

In a concluding remark, the speaker pointed out that "the state of the child for FOCAL is how well families are able to make decisions for themselves." (Contact Ms. Sophia Harris, see Appendix 8.)

National Committee for Citizens in Education

This organization was established in 1973 and is dedicated to increasing citizen involvement in the affairs of public schools and particularly the decision making process. It has a staff of about twenty people and has plans to establish a position for a field representative in the Appalachian area in the near future. NCCE has been concerned with the question of privacy and published a book entitled *Children, Parents and School Records.* Their work was instrumental in the passage of the Family Educational Rights and Privacy Act of 1974 and in establishing due process rights of students. Currently, NCCE is involved in providing training institutes and publications to parents concerning several areas of school parent relations. NCCE offers helpful information through a toll free telephone number (800/NET-WORK). (Contact Dr. Crystal Kuykendall, see Appendix 8.)

Settlement Schools

The original purpose of settlement schools in Appalachia was to provide an education for children at a time prior to the advent of public schools. From the late 1800's and up to 1930 there were about 300 settlement schools in Appalachia, most established by various church denominations. Today there are only a small number of such schools left. Those that do exist have changed dramatically in the last ten years. Henderson Settlement School, for example, carries on forty separate programs ranging from a children's home providing emergency care for non-delinquent children, a demonstration Farm, a craft shop which employs 30 local people, Head Start classes, a volunteer fire department, a home repair program, and the initiation of a full service medical clinic.

In summing up, Reverend Stillwell stated "Those institutions which have survived the last 20 years are now engaged in many things that the founding fathers would never have dreamed of and we are very happy that the churches and people from all over the United States are taking such interest in the work that is going on in Appalachia." (Contact Rev. Don Stillwell, see Appendix 8.)

Cooperative Extension Service

Extension is organized through the Land Grant University in each state. Every state and nearly every county (and city) in the United States has an

extension office thus making it the largest and most extensive public education agency ever developed. Extension's mission is to make useable the knowledge and research of the universities in order to help families in their everyday functions. Nearly thirty percent of Extension's 24,000 employees are working in family support efforts. Because Extension is so widely available and because it serves families regardless of income levels, the speaker urged everyone in the audience to use Cooperative Extension as a resource for themselves and for the families they work with. (Contact Ms. Polly Koehler, see Appendix 8.)

Head Start

Head Start was begun in 1965 to meet the needs of low income preschool children and to involve their parents in the process. Many areas in Appalachia are served by Head Start. In Kentucky, for example, about 2,500 children are served in full year programs. In recent years, Head Start has tried to strengthen quality through improved management techniques (e.g., a Management by Objective grant system, development of Performance Standards, and a biyearly self assessment which includes parents in the assessment process). At the same time, Head Start has continued to be a national demonstration through allowing program variations such as home based services and other service delivery experiments. In some states, such as Tennessee, Head Start and universities have formed strong partnerships which have made many of the resources of the universities more available to rural communities such as audio visual facilities used for public information efforts. This partnership has also made it easier for low income people to achieve academic and professional goals. (Contact Ms. Lucy Biggs, see Appendix 8.)

State Government

The largest increase in services to the Appalachian family in the last ten years has come about through the efforts of state government. Using his home state as an example, Neil Buchanan pointed out that Tennessee has had legislation promoting the well being of children since 1796. However, it is only since 1935 with the passage of the Social Security Act that states have provided service on a large scale. At that time, the AFDC program including cash payments and case work services was begun. In 1967, the Social Security Act was amended to encourage the provision of several types of direct services. This triggered another expansion of state government. One of the recent trends in state services has been increasing recognition of the importance of the preschool years. The three major state human service arms, health, education and social welfare, have all taken steps to serve the preschool child better. The Tennessee legislature has solidified this effort by establishing the Tennessee Office of Child Development. (Contact Neal Buchanan, see Appendix 8.)

Many conference participants were pleased at being able to learn about what other agencies were offering Appalachian families and expressed a need for continued opportunities for linkages among public and private agencies.

During the second full day of the conference, workshops focused on programs and described examples of those demonstrating innovative, single-entry and coordinated approaches to service delivery.

The charts on the next pages give an overview of the scope of comprehensive services provided directly and by referral throughout the 13 state region. We know that among ARC funded child development programs, there are 241 programs or service components reaching at least 222 counties in Appalachia in less than 4 years. In addition, by fiscal year 1974, more than 120,000 children under 6, and more than 104,000 families received direct services through ARC assisted programs.

In this section we have tried to discuss these programs in the context of the needs (described earlier) of Appalachian children for a good beginning, strong family, and the improvement of the economic status of the region. We have considered describing all the interesting programs presented in workshops, but that would be impossible. Instead, we've decided to focus on those programs for which we received more detailed information.

Robert Decker, state program coordinator for the Appalachian Regional Commission, discusses the commission at the State of the Child in Appalachia Conference in Knoxville, Tennessee.

SCOPE OF SERVICES FUNDED BY ARC

Code * — Comprehensive Services	PROVIDED DIRECTLY	PROVIDED BY REFERRAL
Family planning information and supplies	9 States	12 States
Prenatal care for the mother: medical, nutrition educational and social	8 States	11 States
Delivery of the infant and immediate post-natal care for mother and child	7 States	11 States
Education and counseling in child care	13 States	9 States
Adequate food, dental and medical services including medical treatment services for the child for the remainder of his infant and preschool years	12 States	8 States
Systematic cognitive stimulation for the infant and toddler to enable him to benefit from preschool and kindergarten programs	13 States	4 States
Assurance, through care, counseling, and education of an emotional climate conducive to optimal personality development	13 States	5 States
Exposure to social learning situations via trips, group activities and availability of social interaction where these are not provided by the home	13 States	5 States
Day care, [illegible]ght care, and emergency care services when they are needed, including foster care and adoption services	12 States	9 States
Protection from cruelty and neglect	5 States	13 States
Rehabilitation and special education for the handicapped	10 States	11 States

ARC Code, Section 202 D-1

From: **Child Development** A Report By the Appalachian States, August, 1975

POPULATION SERVED, FY 1972 - MAY 1974, BY PROJECT TYPES
149 of 188 Operating Service Projects

	Total 0-3 Served	Total 3-6 Served	Blacks 0-3 Served	Families Served	Poverty Family Served	Total AFDC Served	Total Teenage Mothers	Total Handicapped Served
Comprehensive Day Care	5,783	10,935	3,336	10,099	4,309	6,248	471	882
Comprehensive Home Base	170	428	158	248	206	173	19	20
Comprehensive Child Development	14,910	17,276	4,520	25,725	10,814	6,771	1,322	2,368
Dental Fluoridation	0	0	0	18,071	0	0	0	0
Dental Care	39	28,698	0	350	0	0	520	14
Education	0	26	4	25	0	4	0	4
Family Day Care	96	95	81	137	65	33	8	24
Family Planning	0	0	0	3,052	0	0	530	0
Handicapped Child Development	40	100	3	125	65	4	9	162
Intake/Referral	3,183	3,294	181	4,078	1,574	1,760	393	542
Learning Disabilities	43	213	20	215	75	90	0	40
Maternal/Child Health	7,706	5,002	34	8,845	2,937	867	1,190	927
Mental Health	155	583	40	860	753	406	22	267
Nutrition	1,396	454	0	0	0	0	0	0
Parent Education	112	153	0	284	61	26	36	14
Resource Center	100	1,900	0	1,500	0	0	0	50
Screening for Communication Disorders	0	7,131	0	7,131	0	0	0	0
Social Services	900	650	9	1,008	250	275	65	63
Transportation Services	0	58	0	55	0	0	0	4
Vision	90	225	2	210	0	0	0	0
Totals	34,723	77,281	8,388	82,018	21,109	16,654	4,585	5,401

Source: Child Development Survey, Summer, 1974

A GOOD BEGINNING

Many of the programs described in conference workshops were actively working to overcome the barriers to a healthy beginning, discussed on pages 10-14 of this report. Some approaches included:

1) An Infant Intensive Care program which transports, by helicopter, sick newborns from outlying areas to the University of Tennessee Hospital in Knoxville. This program has treated 3,000 babies and reduced infant death from respiratory crisis by over 95%. (Contact Dr. Thomas Lester, see Appendix 8.)

2) An Infant Care and Resource Center in Tompkins County, New York, funded by a grant from ARC to Tompkins County Day Care and Child Development Council and Cornell University which targets day care services to children with special needs (e.g., single parents, low birthweight, developmentally delayed), serving as a resource for strengthening the care of infants and toddlers in local family day care settings and a training site for infant day care in the entire state of New York. In addition this center serves as a Family Resource Program, offering information, support and guidance to approximately three to five hundred parents of young children in the area. (Contact Anne Willis, see Appendix 8.)

3) A Women, Infants and Children (WIC) high protein food program which offers pre and postnatal health screening, food supplements and nutrition education to over 4,000 mothers and young children in fifteen rural counties of eastern Tennessee. This program is one example of an innovative delivery of WIC through a nonprofit agency. In the nutrition workshop, Dorothy McMabb presented data showing that prevention of iron deficiency anemia and malnutrition in infants can save as much as $1,287.68 in hospital and treatment costs as well as a possible $40,000 in special education costs for the malnourished infant who suffers brain damage. (Contact Dorothy McMabb, see Appendix 8.)

4) A program serving 300 teenage mothers per year in a low income Black community in Columbus, Ohio which brings together health services, WIC, day care, family life education, continuing education for young parents, public schools, vocational planning and job placement and has been able to decrease the infant mortality rate in the area by 50%. This innovative program utilizes up to 300 volunteers a year in a variety of roles as well as helping coordinate many different funding sources. Ms. Bessie King Jackson, program director, reports that they have successfully involved many young fathers in the Lamaze method of childbirth. (Contact Bessie King Jackson, see Appendix 8.)

5) A Young Families Project in Georgia served over 150 teenage mothers and high risk infants with health services *and* ongoing counseling, training support and follow-up through the child's first two years of life. According to the report on *Child Development*, "the program is showing that the result of healthy babies born to healthy, happy mothers is a good, solid beginning rather than later amelioration, child neglect, compensatory education, etc."

6) Statewide comprehensive health care delivery conducted by the Department of Public Health in West Virginia using over a dozen funding sources to meet the health needs of mothers and children. This program provides 1,500 pediatric clinics a year and 6,500 immunizations. As a result, 97% of all first-graders and 95% of all kindergarteners in West Virginia are fully immunized. (Contact Jack Basman, see Appendix 8.)

7) The Holston Valley Nurse Midwifery Project in Upper East Tennessee has been in operation since January, 1974. In this project, operated by the Tennessee Department of Public Health and utilizing ARC and state funds, nurse midwives provide prenatal care to women in the service area of the Holston Valley Community Hospital. The midwives provide labor and delivery care in the hospital including intrapartum fetal monitoring and referring problem pregnancies to a supervising obstetrician for joint management for nearly 400 patients per year. The nurse midwives also provide immediate postnatal care beginning while the patient is in the hospital and continuing post partum referral and follow-up including family planning.

The primary objectives of the project are early identification of pregnancy, good prenatal care, referral of problem pregnancies, delivery and family-centered maternity care, and full post-natal care.

The midwives provide individual counseling to teenagers and private patients join the project mothers in the post-natal classes conducted in the hospital. As a result of the project, almost all pregnancies in the service area are now identified and prenatal care begun during the first trimester. In addition, the number of "walk-ins," that is, women who arrive at the hospital for delivery with no prenatal care, has been reduced from 70-80 to about four per year.

8) Dawn Bolstad is a certified family nurse practitioner providing free services funded by the Lutheran Church to 400 families in a 15 mile radius on a mountain top in Virginia.

Working under the direction of a private family physician, Dr. Janice F. Cable, Ms. Bolstad receives referrals from Dr. Gable and other community members. The long history of nursing care in the mountains has enabled the nursing profession to provide medical care as well as coordinate referral services and offer much needed basic health education.

Ms. Bolstad goes into the home to conduct physicials, take health histories and assess the health status of the family. She tries to coordinate the varying services available to the family to avoid unnecessary duplicating expense and inconvenience for the family. She also makes school health consultations to the local public school for this purpose. A good deal of her time is spent educating the family about chronic and acute conditions and about medicines and how they can best be used. (Contact Dawn Bolstad, see Appendix 8.)

Dr. Jack Basman, assistant director of the West Virginia Department of Health, Grant Leidy, director of a dental services program in Blair County Pennsylvania, and Dawn Bolstad, a family nurse practitioner from Virginia present a nutrition workshop at the State of the Child in Appalachia Conference.

STRENGTHENING FAMILIES FOR CHILD DEVELOPMENT

Many of the programs described in Thursday's workshops were also focused on support and practical guidance to parents (prospective and actual parents) so that the child's full developmental potential could be realized. The problems of early parenthood, isolation of mothers, child-rearing patterns which foster dependency, mental retardation and emotional problems such as xemophobia and school phobia are addressed in programs that try to prevent the emergence of these problems as well as to uncover and treat difficulties early in life. Some examples are:

1) A home-based child development program in Tennessee which uses a multidisciplinary team to provide a broad range of social work, medical and early child development skills aimed at enhancing parent skills. This project serves 2,330 children, half of them under age two and one quarter under age one and makes a special effort to reach families shortly after the birth of the first child, the time when families are most eager for support and counseling. (Contact Corliss Keown, see Appendix 8.)

2) An information and referral service, provided by the Day Care and Child Development Council of Tompkins County, New York, which serves 4,000 children and families with referrals to and supportive counseling about a broad range of child care and development services that are presently available within the county. "We saw that a gap existed between public and private services and the knowledge of the availability of those services. We decided to fill that gap," described one council staff member. The day to day, direct help to families, provided both at a central location and in several rural communities is a key link to development of a coordinated network of child development services, which is the Council's primary goal. The referral and information services are, therefore, closely integrated with the Council's other major services — county wide community planning and coordination for young children; and a resource center offering at-cost supplies, trash-to-treasure ideas, child development consultation, workshops, library, and loan closet, to providers and parents, and extended to rural communities through outreach staff. The *Family Guide to Child Care*, a pamphlet describing specifically what

parents should consider in assessing family day care homes, group care centers and nursery schools is one example of the many materials they have produced. (Contact June Rogers, see Appendix 8.)

3) A child development project in North Georgia which has coordinated two sources of federal funds under the direction of the Georgia Department of Human Resources to offer local communities staff who would help them organize their own preschool programs. VISTA funded 28 Volunteers in 12-13 Appalachian counties; the Appalachian Regional Commission funded supplies and travel. This initial investment has been remarkably successful. Part-day preschool programs serving 250 children are how operating independently, using local resources, in nine counties. (Contact Bob Hudgeons, Department of Human Resources, state of Georgia, 618 Ponce DeLeon, Atlanta, Georgia.)

4) A multi-county day care system in Kentucky, Kentucky Youth Research Center (KYRC), has combined ARC, Title XX, Head Start funds, parent fees and other funding sources to provide a variety of day care centers and home-based child development services to over 2,000 low, middle and upper income families. "We believe that in rural areas it is not possible for communities to work out for themselves different streams of day care and child development services meeting different needs. "It's important to unify the needs within a given community into one program," says Joe Perreault, a program coordinator. In addition this system has hired a qualified nurse, a dentist, two licensed speech pathologists and developed dental, speech and health education aides to provide medical services to the children. KYRC has a contract with the Department of Human Resources to do their own EPSDT screening for eligible children. (Contact Joe Perreault, see Appendix 8.)

5) An Education for Parenthood program sponsored by Save the Children Federation serves 83 teenagers, male and female, almost all under the age of 17. Participants in this program study such subjects as the effects of heredity, nutrition, drugs and diseases in birth outcome, and developmental landmarks in infants and young children. (Contact Al James, see Appendix 8.)

6) Lift, Inc., a six-county Mississippi family nutrition program funded by the Appalachian Regional Commission which provides self-help canning of fresh foods. Families bring their produce to the nutrition centers where at the cost of 10¢ a jar, the food is safely and quickly canned using equipment designed and donated by Ball corporation. Better diets and less isolation among families who come together to use the centers cooperatively are the results. (Contact Jane Mapp, see Appendix 8.)

7) A Family Day Care program in the Georgia Mountains in which seventy-nine independent family day care operators have been identified and in which seven homes are directly affiliated with the program.

Seed money to help finance two of these family day care homes was donated by Banks County Commissioners. The development of twenty project supported homes in seven counties and the establishment of a family day care mother association is projected by Ms. Sue Corley for 1976-77. Ms. Corley, presently with the Georgia Mountains Planning and Development Commission which sponsors the program is a former family day care mother herself. (Contact Sue Corley, see Appendix 8.)

8) A Paraprofessional Child Care System in West Virginia employs and trains 270 day care programs, eighteen day care advisors, four day care specialists, four supervisors and four area administrators. This system has developed a three (3) phase training sequence tailored to an extremely innovative sequence of "day care enrichment" requirements which offer day care providers knowledge and financial incentives in the form of incremental reimbursement rates for improving over time the quality of their services. Both the training and the enrichment sequence are currently being examined by federal agencies and day care programs around the country as a model of support for the growth of quality in day care. (Contact Marge Hale, see Appendix 8.)

9) Project PUSH (Parents Understanding Student Handicaps) has been funded by the Bureau of Educationally Handicapped (BEH) in the Office of Education to provide comprehensive home and center-based services to handicapped children. Currently this Project is planning to develop training in the

needs of handicapped children so that it can be delivered through the ARC Appalachian Satellite Television. In addition, Project PUSH has been funded by the Office of Child Development to be a resource center for Head Start programs in Region III. (Contact April Beavers, see Appendix 8.)

These are but a few of the interesting programs which are delivering supportive services to families in Appalachia. The demonstration programs described at the conference with their emphasis on early intervention, marshalling of multidisciplinary resources in the active promotion of a child's emotional/cognitive development, prevention of mental retardation and parent involvement are clearly bringing about changes. These changes intend to strengthen the Appalachian family's capacity to rear bright, healthy children who value their own culture while at the same time welcoming involvement with the outside world.

Programs like these serve as models for the rest of the nation. Just from our own experience, we can say that at least five of the programs described above are known and valued by child advocates in such faraway states as California, Texas, New Hampshire and Michigan. We agree most definitely with the report on *Child Development* that:

> The Appalachian states have fulfilled their responsibility as a "national child development laboratory." And they continue to address this obligation as they refine programs, systems and methodologies already in place and develop new approaches to the delivery of children's services.[17]

[17]The Kirschner Report, p. 78.

Social Worker Patricia Byler explains the Adolescent Parent Program during State of the Child in Appalachia Conference, Knoxville, Tennessee. The Adolescent Parent Program, a project of the West Virginia Interagency Council for Child Development Services, is funded through the state welfare department.

ECONOMIC DEVELOPMENT

Perhaps one of the most tangible outcomes of the child development programs in Appalachia has been their impact on economic development. The most significant economic impact of child development programs is the assurance of a healthy, fully-functioning and productive adult population. The importance of human resource development in an economic development program has been recognized from the inception of the Appalachian Regional Commission. The investments in hospitals and health centers, in vocational schools, in regional education service agencies and primary care services are all based on the well-supported assumption that the economy of Appalachia cannot reach its full potential until the population is functioning at its full potential. The child development program was initiated as a logical extension of this assumption, and since it is the program which provides services at the earliest age, when the provision of services can have the most significant impact, it holds the greatest promise for real impact on the economy of the Region.

As a by-product, the provision of human resource services also results in the employment of a significant number of professionals and paraprofessionals. Child development projects are no exception.

The economic impact of child development services funded by the Appalachian Regional Commission is very encouraging. Over 5,100 jobs have been created in the Region, most in rural areas and in labor-intensive human service fields. Another 5,000 parents have been able to work or enter job training because of the availability of quality child care fully or partially funded by ARC. Salaries received by persons entering the labor force then place "millions of dollars annually in the hands of local merchants and service business."[18] In the Southeast Ohio demonstration areas, the Kirschner Report goes on to explain, $1.632 million from child development service and consultant salaries have been generated over the last eight years.

> If the employment multipliers developed above are assumed for income multipliers . . . over $5 million in income can be estimated for the Ohio child development demonstration programs in their communities.[19]

Although the multiplier issue is one that has not always been resolved by economists, this report concluded that findings revealed positive trends in several dimensions:

[18]The Kirschner Report, p. 53.
[19]The Kirschner Report, p. 54.

—"increased flow of money through salary expenditures and purchase of goods and services."
—"increased employment opportunities at both the professional and non-professional levels."
—"increased skills among the labor force through training projects and in-service training components of service projects, as well as through the attraction of highly trained professionals to the region."
—"greater access to vocational training or to employment for adults with young children through the provision of day care services."

And finally that "projections for the next five years indicate that, at the current rate, investments in health and child development programs could add nearly *$1 million* to the regional economy by 1980."[20]

Finally, ARC funds have greatly influenced the ability of the Region to attract and use other sources of funds. The following charts give some indication of the growth of this ability in the first five years of ARC support for child development and the scope of project funding.

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[20]*Ibid.*, p. 55.

LEVERAGING OF 202 CHILD DEVELOPMENT PROJECT FUNDS[1]
(IN $1,000's)

	ARC FUNDS	OTHER FEDERAL	STATE	LOCAL	TOTAL
FY 1970	$187	0	$39	$23	$249
% of Total	74.9	0	15.8	9.3	100
Leveraging Ratio	—	100:0	100:20	100:12	100:33
FY 1971	$7,063	$7,533	$70	$577	$15,243
% of Total	46.4	49.5	.4	3.7	100
Leveraging Ratio	—	100:106	100:1	100:8	100:115
FY 1972	$18,477	$32,769	$153	$1,816	$53,215
% of Total	34.7	61.6	.3	3.4	100
Leveraging Ratio	—	100:177	100:1	100:10	100:188
FY 1973	$15,632	$9,541	$49	$2,471	$27,693
% of Total	56.5	34.4	.2	8.9	100
Leveraging Ratio	—	100:61	100:.3	100:16	100:77
FY 1974	$25,522	$21,179	$613	$6,164	$53,478
% of Total	47.7	39.6	1.2	11.5	100
Leveraging Ratio	—	100:82	100:2	100:24	100:108
TOTAL	$66,881	$71,022	$924	$11,051	$149,878
% OF TOTAL	44.6	47.4	.6	7.4	100
LEVERAGING RATIO	—	100:106	100:1	100:16	100:123

[1]Source: ARC Report to Senate Public Works Committee, February 7, 1974.

TOTAL PROJECT FUNDS BY PROJECT TYPE BASED ON 208 PROJECTS OPERATING AS OF MAY 1974

Project Type	ARC Funds	Title IV-A Funds	WIN Funds	USDA Reim-burse-ment	Medicaid Reim-burse-ment	Other Fed. Funds	State Funds	Local Funds	Total Project Cost
			0	0	0	0	0	0	1,850
Visual Screening/Treatment	1,850	0	0	0	0	0	4,021	3,000	303,620
Family Planning	124,293	172,306	0	0	15,030	12,000	356,638	235,248	3,219,370
Maternal/Child Health	2,600,228	226	0	0	0	0	0	2,659	1,020,527
Nutrition	226,842	751,026	0	0	0	0	0	30,313	107,434
Nurse Practitioner Train.	7,362,957	9,515,692	376,653	145,825	0	29,417	274,100	765,824	18,470,468
Intake/Referral	935,287	2,194,028	0	0	0	119,600	90,446	183,892	3,523,253
Family Day Care	316,767	172,774	0	0	0	0	2,514	17,382	509,437
Technical Assist./Coordin.	1,750,436	652,203	0	0	0	12,145	137,251	27,213	2,579,248
Parent Education	340,377	26,161	0	0	0	0	960	113,738	481,236
Social Services	180,403	644,854	0	0	0	0	35,631	0	860,888
Learning Disabilities	78,809	235,086	0	0	0	0	0	7,481	321,376
Mental Health	455,052	46,879	0	0	0	6,000	42,124	92,190	642,245
Screening for Comm. Disorders	18,909	26,057	0	0	0	0	0	157	45,123
Teenage Parents	39,313	116,032	0	0	0	0	1,910	0	157,255
Transportation Services	34,434	0	0	0	0	0	0	2,724	37,158
Dental Services	204,476	0	0	0	0	0	29,896	6,640	241,012
Education	30,880	0	0	0	0	0	0	26,718	57,598
Comprehensive Child Dev.	12,030,625	6,198,550	94,629	469,891	0	814,871	129,940	1,085,816	20,824,322
Handicapped Child Dev.	299,143	0	0	0	0	11,585	0	15,114	325,842
Resource Center	22,133	0	0	0	0	0	0	14,780	36,913
Comprehensive Home Base	245,192	280,784	0	0	0	0	0	0	526,102
TOTAL	27,415,527	21,032,784	471,282	615,716	15,030	1,005,618	1,105,431	2,630,889	54,292,277

Source: Child Development Survey, Summer 1974

Question III

WHAT DO APPALACHIAN CHILD DEVELOPMENT PROGRAMS NEED?

We have examined what is known about the needs of Appalachian children and have also looked at programs designed to deliver services for meeting those needs. We shall now examine the needs of these programs in terms of in-service capability and resource development.

FINANCIAL NEEDS

The ARC money that has funded Child Development programs since 1970 and health programs since 1965 was offered with the expectation that such money would "leverage" other sources of money; that other federal and state funding sources would be attracted to the program so that dependency on ARC would decrease with time. Part of the attraction was that ARC money could be used to match other federal grants and that it could also be allocated without regard to income. The degree to which programs have become more self-sufficient, less dependent on ARC funds, and able to survive with other sources of income was a major concern among conference participants. According to a 1974 survey, 2 out of every 3 health projects that started with ARC funds are still operating. Others have reduced services. "There are not yet enough projects that have passed the maximum 5 years of ARC funding to warrant the development of strong conclusions," explained the Kirschner report. However, in examining the relationship of ARC funding levels to project continuation, it should be noted that none of the projects that continued after 5 years started with 100% ARC funding. Perhaps in these instances ARC money was used to fill gaps in funding sources rather than to leverage other funds.

These observations, cited in part by the 1974 Kirschner report, reinforce the need for early and continued community support as well as the ability of program leadership to become knowledgeable about other funding sources. This expertise in grantsmanship procedures, proposal writing, and foundation research was cited by the Kirschner study as lacking among ARC programs attempting to leverage other funds.

RESOURCE MOBILIZATION CENTER

One Appalachian program which has worked to help local communities develop this expertise is the Resource Mobilization Center (RMC) under the direction of Mr. Tom McClure (see Appendix 8). The only resource mobilization demonstration effort in Appalachia, RMC has been operated by Save the Children Federation for the Department of Human Resources in Georgia, using initial ARC funding. It was intended to be a model for other states, as well as to develop local capacity to plan, implement and support programs for children.

In early 1975, many Georgia Appalachian child development programs were worried about having to close, due to the culmination of their ARC support. The Resource Mobilization Center was designed to provide training and technical assistance to a 35-county area, specifically to the state Department of Human Resources staff, program operators, and staff of coordinating and district planning agencies in resource development, public information and public relations skills, planning techniques, program management, budgeting and supervision, board and policy advisory committee development and the use of library materials for research.

As a direct result of RMC consultation, four programs have tapped substantial sources of funding. In addition, $32,000 was received by three programs as a result of RMC training. Two program grants, worth $75,000, are still pending. The future looks good for program continuation and expansion in North Georgia.

The Resource Mobilization Center has also disseminated information and materials to all 13 states in Appalachia and to other child development programs in non-Appalachian Georgia. RMC served as one coordinator for the first "State of the Child in Appalachia" conference. At present, RMC is sponsored by the Community Development Foundation, a private foundation related to Save the Children Federation. Training and technical assistance, for a fee based on the cost of service, is now available on a request basis to child development programs in Appalachia or in the rural South.

The Resource Mobilization Center was one of the topics discussed at the workshop on Resource Development. Workshop leaders Tom McClure, Dix Briesemer and Thomas Murray of New York, explained the need for programs to rely on the skills of Boards of Directors or other individuals who can be involved. Workshop leaders presented a recommendation that each program establish a fund raising development committee, comprised of Board members, parents, and community members — especially those most influential in the community for the purpose of involving a wider circle of people in the fund-raising process. We mentioned the need for community support

earlier. This is one way to seek the support and participation of the community leadership.

The other, very important reason for the need to educate the community about child development programs is a change in the place of decision-making about funding from the federal level to the state and local levels. Elected officials and government agencies at local levels, responding to what they know about local needs and public support for programs to fill those needs now make major decisions affecting the survival of ARC funded programs. This is part of a new trend in government spending called "new federalism." The workshop on this issue explained new federalism as:

> 1) An effort to promote tax reform by retaining the current efficiency of the federal government in collecting taxes but returning the revenues, with fewer restrictions to state and local governments for decisions on expenditures;
>
> 2) An effort to facilitate and increase spending on direct services by decreasing the administrative and technical functions involved in a multilevel service delivery system. Tasks such as program and fiscal audits, case processing, and certain layers of dysfunctional planning are targets of the drive for efficiency;
>
> 3) An effort to strengthen the capacity of state and local governments to determine and solve local problems by decreasing the federal policy-making authority while increasing state and local financial resources. It also includes the concept of recruiting talented people in state and local government and relying on elected officials as one of the best sources of decision making in a community;
>
> 4) An effort to decrease some of the weaknesses of federal "categorical" programs while making it possible for state and local groups to form their own conceptualizations of problems and new solutions.

While this shift of decision making and accountability from federal to state is in its formative stages, legitimate concerns about the impact of this trend were expressed by workshop participants.

At present each available funding source requires a different set of standards, eligibility requirements, paper work and level of administration. Practitioners whose skills lie in direct service to families expressed feelings of being lost in a maze of varying requirements. In addition, many practitioners expressed frustration at having to spend time and talent best suited for work with families in the strange and unfamiliar tasks of constantly securing funds for their programs. Additional burdens will come with new federalism because this concept involves more than applying to funding sources; it involves getting citizen participation in the process of making needs known in a community and in developing a planning process. Local planning groups must also develop strategies for involvement in the decisions made at the local and state levels.

Another concern expressed was whether local decision makers could adequately represent low income and minority interests. The effectiveness of the strategies developed by planning groups will be tested here.

It is clear that innovation and flexibility must exist at the lowest level of planning. Groups must think beyond categorical grants, as did those who have utilized ARC monies since its change to a block grants approach. Clearly many conference participants expressed over and over the need for significant technical assistance in the new fund raising/survival strategies that will be necessitated by "new federalism."

THE ARC

Congress authorized the creation of ARC as a unique Federal-state partnership through enactment of the Appalachian Regional Development Act in 1965. The special problems of Appalachia in infant mortality, retardation, and early childhood care generally stimulated the creation of the Child Development Program in 1969 which provided for planning, gathering resources and implementing programs for the 0-6 group, including a comprehensive approach to early health, social, nutritional and educational services. Evident needs existed for: a) a planning mechanism at the state level; b) comprehensive services focused on preschool years; c) innovative demonstration programs having some impact on the development of other programs in the state; d) plans that considered how projects would be funded in the future; and e) identification of other "bridging" funds.

States currently receive a single allocation of ARC funds for non-highway programs; this process makes considerable demands on the development of state and subregional investment plans across a multiplicity of economic and human services. The same concerns exist here as they do for new federalism and its impact. Of prime importance is the uncertainty of the bases on which these crucial decisions are being made — needs or power structure? Despite these concerns, however, the uncategorical funding of ARC monies has fostered the development and demonstration of many innovative programs and methods. The 1975 Senate Report concerning continuing legislation for the ARC stresses the development of a cost-effective program approach, emphasizing underdeveloped areas in all states, interfacing specifically with Title XX of the Social

Security Act, and achieving maintenance of effort whereby ARC funds cannot replace other federal or state funds already available. This places the responsibility on the states to identify blockages to receiving other federal funds and to present the difficulties to Congress in hope of regulating changed procedures.

The ARC workshop concluded with the interesting observation that human services must constantly justify their economic impact in the Region; that it is not enough for them to be judged purely on the basis of how well they deliver services to families. Perhaps greater cooperation and coordination among different service programs would exist if human services were asked to justify their existence primarily on the basis of how efficiently they are delivered. We would like to add the suggestion that, while it is important for human services to analyze their impact on economic development, it would also be valuable to require "purely" economic development programs (such as highways and buildings) to demonstrate their impact on human needs and especially on the lives of families. This conceptual framework would be most helpful in achieving a balanced development of the Region's resources.

There were workshops devoted to specific federal programs for the purpose of familiarizing these potential grantees with other sources of money and to assess how well they are serving Appalachian children. Within almost every workshop there was discussion of Title XX, CETA and WIC. We shall attempt to present in the following portion of this report, the highlights of these programs as well as other sources of federal monies which could be used to strengthen programs designed to serve Appalachian children and families.

TITLE XX

1935: Social Security Act signed;

1956: Social services recommended; 50% matching rate for income maintenance;

1962: 75% matching rate for programs serving the disabled;

1967: Title IV-A of the Social Security Act enacted emphasizing services that would enable people to work. States began using this money for their own state programs and escalated the cost to well over $4 billion.

1973: A ceiling of $2.5 billion was placed on Title IV-A expenditures. HEW also wrote restrictive regulations on eligibility which threatened the survival of many social service programs. The overwhelming negative response from the public caused Congress to put a moratorium on these HEW regulations until December 1974. This in turn caused the states to hesitate before commiting Title IV-A money to day care and other projects. The confusion and delays resulting from the changing regulations meant that the expected leveraging of Title IV-A funds did not happen in the early 1970's in Appalachia. The rest of the country also felt the restrictions of this situation and so an ad hoc social services coalition formed and worked with HEW representatives and congressional aides to reorganize the social services amendment. The outcome of this collaboration is what is now referred to as Title XX of the Social Security Act, signed by the President January 4, 1975.

Title XX changed Title IV-A in three major ways: eligibilitv, state decision-making and the planning process. Tying eligibility to income rather than welfare status is an important change. Anyone whose income is below 80% of the state's median income can receive free services; anyone with between 80% and 115% of the median income can be charged a fee based on a sliding scale. The important thing to note is that each state has the responsibility of determining what the percentage of the median income would be for eligibility. These figures vary greatly from state to state. On the whole, states are playing a much larger role in making such decisions as: a) the services to be provided; b) to whom and how many people these services will go; and c) at what cost. Title XX is a move toward decentralization and a stepping stone to a total block grant approach to service delivery. The current administration has proposed to turn Title XX into a system of block grants with few federal restrictions and no requirement that states provide a matching share. (Title XX at present is a reimbursement program where states must provide 25% in order to receive 75% federal funds.) Finally, the public planning process in Title XX creates many opportunities for citizens and special interest groups to make their input into the State Plan. Once again, the extent to which states actually use public comments varies from state to state. In the Appalachian states, the ADD's and state Interagency Councils have tried to reliably assess the need for services among local residents, so that the concerns specific to Appalachian children and families may be reflected in Title XX State Plans.

A review of all State Plans for FY'76 indicates that day care services constitute more than 25% of the $2.5 billion Title XX budget. Approximately 837,000 people are being served for a cost of nearly $600 million federal dollars; when including state and local matching dollars, day care services cost over $1 billion.

Five of the Appalachian states (Kentucky, Ohio, South Carolina, Tennessee, and Virginia) are providing less than 25% of their Title XX allocation for

day care, while New York and North Carolina have been close to 50% for child care services in their states. It is often difficult to examine national or state statistics and determine whether Appalachian families and children are being adequately served. The cost per child may be greater in some parts of Appalachia due to extensive transportation costs or to high costs of renovation in older facilities. There are very few states that make counties accountable, so that figures for service utilization are rarely available for federal programs on a county-wide basis.

Some of the problems as expressed in the workshop on Title XX relate primarily to the administration of the program at all 3 levels of government:

1) FEDERAL LEVEL

a) The regulations written by HEW are more restrictive than the legislation itself which has created some problems for local, state and regional people when attempting to interpret the law. The regulations have also "dampened" the high expectations that citizens had for Title XX when it was originally passed. Many thought that it would be the answer to most problems. During the first year, however, there was more needs assessment and planning than there was expansion of services. It is still hoped that this will change as providers and administrators become more acquainted with the program.

b) Auditing requirements are extensive. The increased paper work and reporting requirements are extremely time consuming, particularly for smaller programs lacking additional clerical help or administrative support.

2) STATE LEVEL

a) The flow of cash from state to local levels is often not as efficient as it could be. When local people are not knowledgeable about the program, many petty concerns give rise and negatively influence provider relationships with the state. Reimbursement rates are a problem because costs do differ from area to area and states do not always take this into account when setting rates.

b) State people are often overwhelmed by the administrative work demanded of them and their apprehension is noticed by providers. In addition, state offices are often understaffed or are staffed with those lacking the necessary expertise.

c) The state auditors are often perceived as "picky" and causing problems for providers. Some conference participants described the difference between Head Start monitors (whom they said use a "Let us help you be successful" approach) and Title XX monitors (whom they said use a negative "Let's find out what's wrong here and sanction you for it" approach).

3) LOCAL LEVEL

a) The 25% local match money is difficult to raise, particularly when the state has allocated very little money for match. The low economic base of rural Appalachia also creates difficulties in raising local match.

b) Lack of information and understanding of the law; lack of good working relationships with state people who can offer technical assistance; and lack of an effective communications network so that information and expertise can be shared among Title XX grantees. All these factors contribute to the everyday problems of local providers in using Title XX money.

Title XX made the Federal Interagency Day Care Requirements (FIDCR) law and made changes in staff-child ratios for infants and school age children in day care, as well as threatening to penalize any program out of compliance with FIDCR by taking away 100% of their federal support. The ratio changes, as promulgated by HEW who is also responsible for conducting a 2½ year appropriateness study of the standards, are as follows: 1:1 for infants under 6 wekes; 1:4 for children under age 3; 1:5 for 3-4 year olds; 1:7 for children age 4-6; 1:20 for 6-9 year olds and 1:25 for school age children 10-14. Most state standards are significantly looser than these standards.

STAFF-CHILD RATIOS FOR DAY CARE CENTERS
(Number of children per adult by age of child)

YEARS	Under 1	1-18 mos.	18 mos. - 2	2-2 1/2	2 1/2-3	3-4	4-5	5-6	6-7	7-8	Over 8
AVERAGES	5.15	5.54	6.02	7.28	8.10	10.28	12.35	15.35	17.09	17.2	17.6
Alabama	5	5	5	5	10	10	20	20	22	22	25
Georgia	5-7	5-7	8-10	8-10	8-10	10-15	15-18	18-20	20-25	20-25	20-25
Kentucky	6	6	6	8	8	10	12	15	15	15	20
Maryland				6	6	10	10	13			
Mississippi	1-4	4	4	4	4	5	7	7	15	15	15-20
New York	4	4	5	5	5	5	7	7	10	10	10
No. Carolina	8	8	8	12	12	15	20	25	25	25	25
Ohio	8	8	10	10	10	15	15	20	20	20	20
Pennsylvania						7.5	10	10	12.5	12.5	12.5
So. Carolina	6	6	6	8	8	10	14	15			
Tennessee						10	15	25	30	30	30
Virginia	3	3	3	10	10	10	10	10	10	10	10
West Virginia	4	4	4	8	8	10	12	15	16	16	16

Source: Child Day Care Management Study, SRS, HEW, p. 97

A law was passed suspending FIDCR until February 1976 after which time providers expected Congress to either loosen the ratios, suspend them, or fund them. A bill, called HR 9803 with $250 million for day care programs to meet FIDCR was passed by both House and Congress, vetoed by President Ford and sustained by 2 votes in the Senate. Finally, in September 1976, President Ford signed H.R. 12455, passed by Congress as an adapted version of H.R. 9803. The new bill provides an additional $240 million for day care, allocated among the states on a population basis, and suspends federal staffing standards for preschool children until October 1, 1977, when the HEW Appropriateness study of the Federal Interagency Day Care requirements will have been completed.

ARC standards for child care do not recommend a specific staff ratio for children of different ages. This issue was of particular concern to those in the private sector who only serve a few Title XX eligible children. This and other aspects of FIDCR were discussed in many conference workshops with the recommendation that more money be allocated to programs so that they could hire the staff necessary to meet the ratios.[21]

Title XX will probably be the greatest resource for those programs phasing out ARC funds. Hopefully, ARC money has been used as match money for Title XX. There were great hopes for an ARC interface with Title IV-A before the $2.5 billion ceiling was put on it. The extent to which this was possible was further limited as restrictive regulations accompanied the new ceiling. (See Chart on page 37.) States were turning back to the federal treasury close to $1 billion each year in unused money. The requirements for use were too complicated and there wasn't enough local match available. For FY'76 under Title XX, nearly $2.4 billion of the $2.5 will be spent. ARC has contributed to this effort and ARC demonstration projects have benefited *despite* the administrative problems of Title XX implementation.

Other federal programs capable of providing resources to child and family programs in Appalachia were discussed in the workshops. They are described below.

CETA (Comprehensive Employment and Training Act)

Part of the Department of Labor's effort to alleviate higher unemployment as well as provide much needed assistance to service agencies, is CETA. Comprised of training (Title I), public service employment (Title II), national programs support (Title III and IV), emergency public service jobs (Title VI), and summer youth employment, CETA can provide staff to day care centers, health clinics, or advocacy groups.

David Sweitzer of the Chattanooga Area Regional Council of Governments in Southeast Tennessee (see Appendix 8) has had experience in helping one Tennessee county apply for and use CETA funds. Child advocates in Bradley County wanted to provide a multidisciplinary child abuse prevention and treatment program, but were unable to acquire HEW funding to do so. Mr. Sweitzer approached the county judge and clarified what was needed to deliver these services. The judge then approved the hiring of CETA trainees for the program. Currently, this child abuse project is funded by Title XX, matched with Community Development funds which have been provided by a municipality. Plans include an expansion of this CETA-funded child abuse prevention effort into four or five other counties.

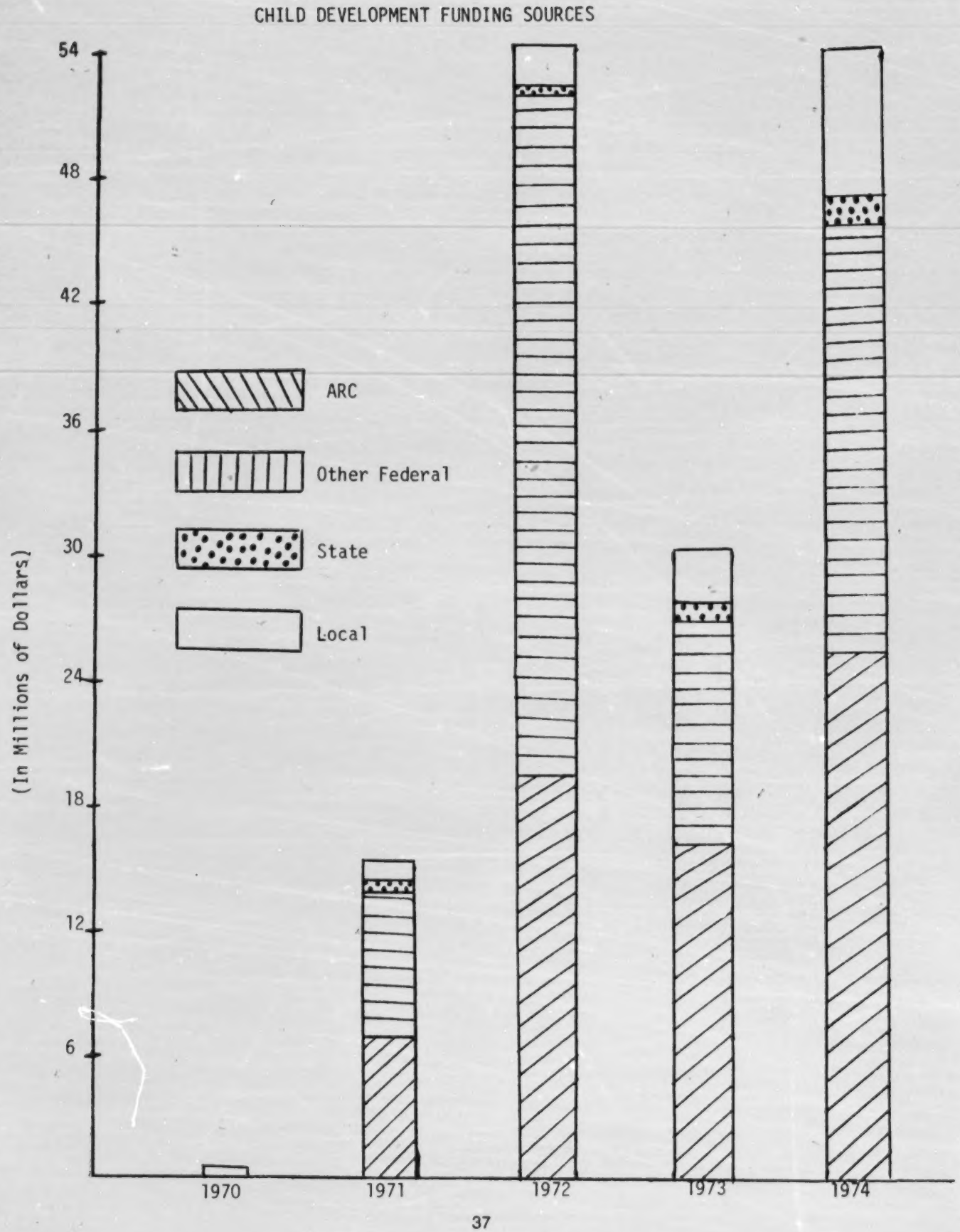
In describing this program Mr. Sweitzer remarked, "Child development advocates have really overlooked CETA as a source of funding for programs, especially in rural areas. They are ignoring one of the best resources for the building of a constituency for children in local areas." The three conditions under which CETA funds can be obtained and most effectively used, according to Mr. Sweitzer, are: 1) support of public officials such as judges or others designated with approving CETA funds, 2) assistance to the public official in selecting the appropriate persons to work in child development, 3) training for the persons selected. "In my experience," says Mr. Sweitzer, "most judges seem eager for responsible groups to step forward and offer to hire and train CETA applicants."

More information about the coordination of CETA funding for human services programs can be obtained in a booklet entitled *CETA and HEW Programs*, published by the HEW Office of Manpower in Washington, D.C.

COMMUNITY DEVELOPMENT ACT (CDA)

This block grant to localities provides one of the only sources of money for building and renovation for service agencies. Twenty percent of the money is available for direct service. This authorization is somewhat interchangeable with Revenue Sharing. Community Development funds are spent at the discretion of local governmental units, based on what they see as the providers in their areas. Community Development funds can be matched with Title XX funds, providing certain geographical restrictions are met. Program administrators using Community Development funds have to document

[21]Part of the President's proposed changes in Title XX include the elimination of federal standards so that states can enforce their own standards for day care.


CHILD DEVELOPMENT FUNDING SOURCES
54
48
42
36
30
24
18
12
6
(In Millions of Dollars)
ARC
Other Federal
State
Local
1970
1971
1972
1973
1974
37

that they are serving a certain number of people in an approved geographical area.

REVENUE SHARING

As with all block grants, a number of special interest groups compete to acquire a portion of the available revenue-sharing monies. While the decision making rests at the local level, in the hands of officials close to the community where the money will be spent, competition among "needs" is keenly felt. Across the country less than 1% of revenue sharing has been spent on child care; in communities where child advocates have made their voices heard, revenue sharing has been extremely effective in building coalitions, networks, and systems of children's services. Revenue sharing, like Community Development funds, are also grants directly to local government units. Those units are then free to spend those funds on whatever they designate as priorities.

EPSDT

The Early and Periodic Screening, Diagnosis and Treatment Program began in 1967 as an added provision to Medicaid, (Title XIX, of the Social Security Act) and is desginated to serve low income families through an ongoing system of preventive and curative services. EPSDT changed Medicaid by requiring that preventive services be given to eligible children free of charge. It also required that Medicaid play an active role in reaching out to families that may be in need of assistance. "These additions to Medicaid represent a recognition of 2 facts: 1) it is just as important to help children stay well as it is to take care of time when they are sick, and 2) the mere availability of Medicaid services will not assure that children use them."[22] It is up to the states to define the components of EPSDT and who is responsible for carrying them out. In 1971 and 1972, HEW discovered massive underutilization of the funds for this program. A series of lawsuits found the states negligent and a penalty was devised for states that did not make an effort to use EPSDT. Ten states have been penalized so far. It is unfortunate that a negative incentive had to be created in order for states to participate in such a worthy endeavor.

Some of Appalachia's problems in using EPSDT as cited in the EPSDT workshop were: 1) lack of a basic program; 2) inadequate outreach; 3) inadequate notification to programs and recipients; 4) lack of available screening services and/or treatment and follow-up; and 5) lack of efficient management at the state level.

[22]Brown, Donna. "EPSDT Provides Health Care To Needy Children." *VOICE FOR CHILDREN*, May, 1976, page 4.

The efficiency of the EPSDT program varies greatly from state to state. Much depends on who is providing the service. If it is the health department, services are usually clearly defined, excellent records kept. It is also easier for child care programs to negotiate services and assist in outreach and follow-up efforts with a single institution. On the other hand, there is difficulty getting treatment for a diagnosed child until it is time for his next periodic screening. The health department may hinder the provision of comprehensive care due to the lack of a single entry point.

If the provider of EPSDT is a physician or local clinic the chances are greater for more thorough treatment and follow-up and integration with other health services. Record keeping is extremely difficult, and doctors often do not participate due to low fees and increased paperwork. It is significant also that in Appalachia, child development programs such as the Kentucky Youth Research Center have developed good linkages, and even contracts, with EPSDT.

One other problem mentioned at length was the low participation of dentists in Medicaid. Physicians are often unaware or neglectful of dental problems so that few referrals are made if problems are recognized. The critical shortage of dentists in Appalachia (see Appendix 1, page 49) makes dental screening even more difficult.

The possible sources of information about EPSDT at the local level are: 1) medical assistance division of the State Welfare Agency; 2) local welfare department; 3) local health department; 4) Health Coordinator of local Head Start Center; or 5) the local chapter of the American Academy of Pediatrics.

WIC

Given what we know about human needs in Appalachia and the emphasis of ARC funded programs on single entry point comprehensive services which reach children at the earliest possible moment, the Women, Infants and Children (WIC) special supplemental food program seems tailormade as a great opportunity to strengthen all Appalachian child development programs. Many concerns and much interest in WIC were expressed at the Conference. WIC is a program for pregnant women, new mothers, infants and young children under 5 years of age who are determined as nutritionally "at risk."

Under the WIC program, infants can receive non-fortified formula, cereal high in iron, and fruit juice high in Vitamin C. Women and children can receive fortified milk and/or cheese, eggs, iron-rich cereal and juice high in Vitamin C. Although the funds usually flow to State Health Depart-

ments, health clinics and non-profit agencies can contract with their state departments to provide WIC.

Unfortunately, WIC is a program which has been grossly underutilized nationally. States have been pressing the United Staets Department of Agriculture for years with requests to expand caseloads and serve more mothers and children, only to be told that this was impossible. In the meantime $125 million in funds already *appropriated* by Congress for WIC were going unspent. Consequently, states were having to freeze their caseloads while assembling requests to expand. Tennessee, for example,as of late March 1976 was allowed to serve 13,257 persons and had requested funds to serve 27,000 additional persons. On April 15, 1976, Tennessee was allocated enough funds to serve 726 additional persons. This picture was very similar in most of the Appalachian states. (See Chart on this page).

The frustrations caused by this federal cold shoulder to malnutrition in Appalachia was expressed by many conference participants. In the Nutrition workshop, for example, participants discussed their chagrin at not being allowed to use unspent administrative funds to expand direct services to families. One participant expressed it this way:

> One of our problems is that we are contracted for $800,000 to serve 2,200 people — food and administrative costs. We can't spend all that money on so few people. But they won't allow us to increase our caseload. So we'll have to return the money and then they'll say "see, the money is not being utilized, why should we fund them in the first place?"

This dreary picture should be changed however, as a result of a June 1976 court decision in which a U.S. District Court Judge ordered the Department of Agriculture to spend $687.5 million on WIC over the next 27 months. Judge Casch ordered USDA to act immediately on pending applications. The opportunities for Appalachian child advocates to increase substantially their state's participation in WIC over the next two years have been greatly enhanced by this court decision.

WIC AT A GLANCE
IN THE 13 APPALACHIAN REGIONAL COMMISSION STATES

STATE	CASELOAD	REQUESTS[1]	NEW ALLOCATIONS[2]
Alabama	19,996	19,600	-----
Georgia	22,632	------	1,158
Kentucky	12,053	9,417	707
Maryland	16,080	800	366
Mississippi	16,351	5,000	591
New York	78,901	32,616	-----
North Carolina	21,341	16,680	1,039
Ohio	43,771	150	-----
Pennsylvania	44,377	23,700	2,161
South Carolina	28,145	8,800	-----
Tennessee	13,257	27,000	726
Virginia	925	9,550	2,815
West Virginia	7,605	------	543

[1]Included in 1976 amendment
[2]Ammouncements made April 15, 1976

Source: The Children's Foundation

PROGRAM ADMINISTRATION

Four of the primary functions of administrators who manage child care delivery systems are: 1) finance; 2) personnel; 3) staff education and training; and 4) programming. We have discussed the need for multiple funding and the potential sources of funds and how to apply for them. The art of proposal writing and grantsmanship, as discussed in the workshop on Resource Development, is described in Appendix 5.

The recruitment and selection of competent staff is another important need for efficient program operation. One criteria for selection is sensitivity to the culture and heritage of Appalachian children. These programs are often the first social setting for the child and it is important that the experience occur in a warm and accepting environment.

Supervision of staff is a central function of administrators, and much time was spent discussing this in the workshop on Program Administration led by David Sweitzer of Tennessee. In this session Mike Harter of Family Development Programs in Ohio emphasized the need for supervisors to become "initiators" rather than "reactors" by developing an approach to supervision which is grounded within the context of realistic philosophical and psychological principles. For example, the affective objectives for which a day care program is established provide the basis for the supervisor's interaction with staff. Participants in the workshop analyzed the differences between: 1) day to day supervision of staff, 2) formal supervision of staff, and 3) formal outside evaluation of staff. Copies of a formal instrument used by supervisors to evaluate staff performance in Virginia were distributed by Norma Gray of the Interagency Council on Child Development in Huntington, West Virginia. Mike Harter and Jane Varner of Ohio distributed copies of a formal instrument used by teams which annually evaluate the child care programs in Ohio.

COORDINATION AND PLANNING

As previously discussed, continued attempts at effectiveness in coordination and planning typify the Appalachian child development effort. The state of Georgia, for example, using ARC funding, has developed a project which intends to develop an Appalachian Health and Child Development Plan, a Grants Management Manual which will be used to monitor program and fiscal requirements of ARC grantees, a technical assistance system to assist communities in operating programs and in applying for ARC funds, a self-evaluation system for programs, and a fiscal plan to provide timely flow of information and funding to local projects.

PARENT AND COMMUNITY INVOLVEMENT

One frustrating aspect of the conference was the lack of statistical data substantiating the experiences and beliefs of service providers and practitioners. Statistical documentation is important because it is one of the most powerful tools in *advocacy*. Such efforts include convincing policy makers and elected officials of the needs of the Region's people, monitoring and evaluating the utilization and distribution of federal and state resources, and raising the consciousness of the community.

One often underutilized resource for assisting in advocacy efforts is *parents*. Many conference participants expressed the conviction that programs underestimate the powers of their parent group by forgetting that parents are also tax paying, voting citizens of the community. In addition there are no better representatives of the needs of children than the parents of those children. Programs, however, need to keep parents informed as to how their services specifically meet the needs of children. Not only does this serve to strengthen the family, it is also a way to involve parents in efforts to educate their communities as to the value of child health and development services. Involving parents is sometimes difficult because of conflicting schedules and inconvenient hours. There is no reason why parents must make their contributions during working hours however. Parents can arrange on their own time to speak to neighbors about the good things happening to their children in this program. In order to begin involving the outside community one can begin by sending already recruited community members, i.e., parents, back into the community. Parents are also able to inject their perspectives of community needs into the program so services can begin filling gaps and adapting to perceived needs at the local level.

ARC is an example of this effort for it was "created in response to perceived and documented inequities in the distribution of national resources with a view toward redressing the imbalance."[23] The development of services to meet unmet needs can occur on the local level if an organized and effective advocacy posture is adopted by existing providers, with assistance from parents and other interested community members.

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[23]The Kirschner Report, p. 78.

Advocacy can be a viable system-leveraging technique. In addition to monitoring state and federal expenditures, and raising the awareness of the community towards problems and proposed solutions, advocacy efforts can create a body of knowledgeable and committed individuals capable of influencing decision making processes at the state and local levels. This is particularly important for groups in the Appalachian region in order to inject the concerns of the region into otherwise urban-biased policies.

. . . Advocacy must be accepted as a legitimate, proper, important goal. It should have its own allocation of resources if it is to be more than an afterthought . . .[24]

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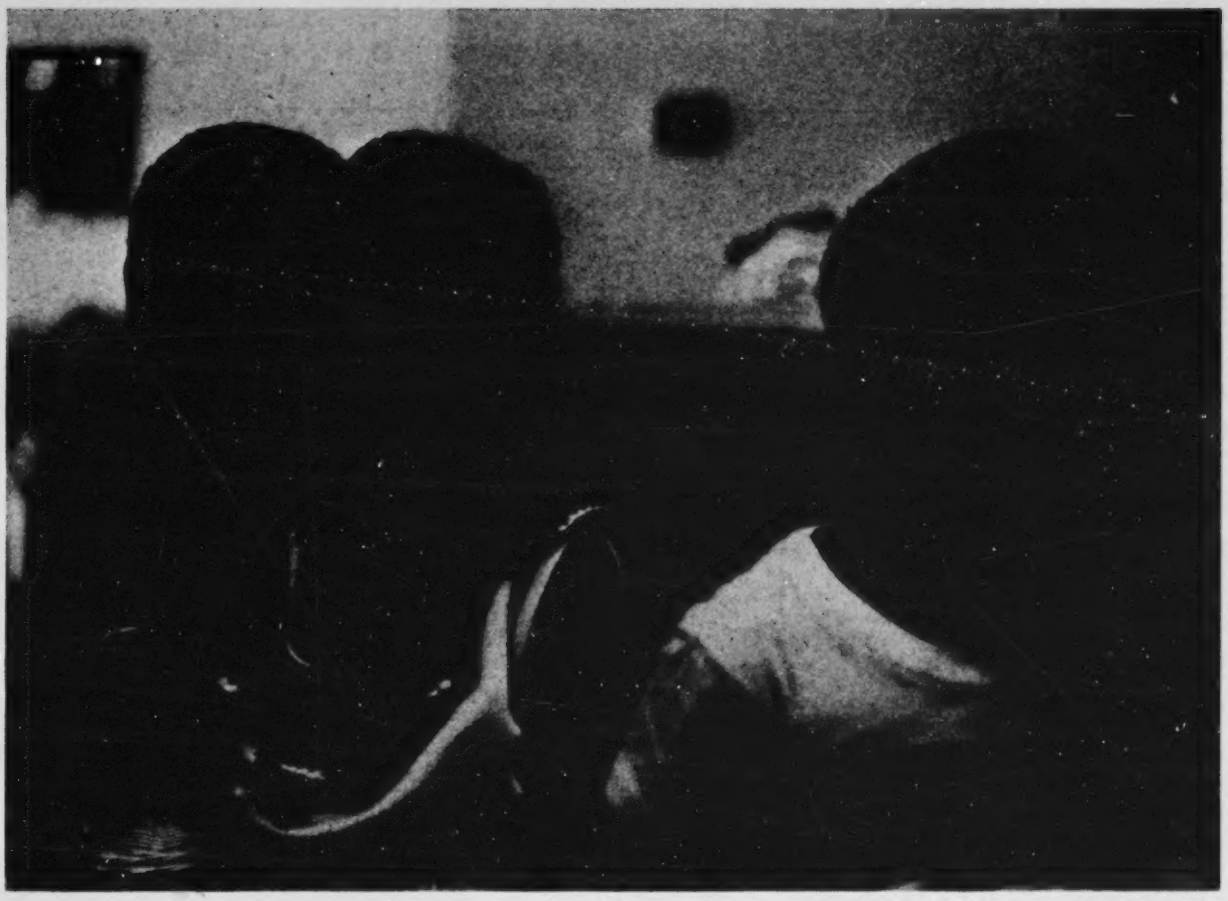
[24]The Kirschner Report, p. 80.



Interagency Child Care Center, Wheeling, West Virginia

CONCLUSION

HOW WAS THE CONFERENCE RECEIVED?

Conference planners decided to distribute an evaluation sheet and ask conference participants to describe their opinions of the conference and suggestions for improvement. Seventy-six (76) evaluations were returned. Of these evaluations, 44 were *very* positive. Typical comments written by these conference participants were:

> "I felt that the conference was the most informative and most organized that I have ever attended. The selections of workshops were varied and presented by interesting persons." (Early Childhood Educator)
>
> "This was the most dynamic workshop I have attended." (Social Worker)
>
> "I enjoyed this conference, especially the opportunity to talk with others working in programs with children." (Accountant)
>
> "The conference was very good. Most comments from participants were very positive. The fact that people who are actively involved in programs for children in Appalachia were here made it most beneficial." (Director of an Interagency Council in Child Development)
>
> "I found the conference to be very interesting. I feel as if the sessions I attended will help to extend better services in the field where I work." (Home Educator)
>
> "The conference was the most productive three day conference that I have ever had the fortune to attend." (Child Health Analyst)

Seventeen (17) evaluations were returned with mixed reactions, both positive and negative. While all of these conference participants did feel that the workshops were interesting and informative, most negative comments centered on the criticism that sessions were too long and presenters talked too much instead of encouraging interaction. From our perspective lengthy sessions and presenters anxious to explain their views are frequent features of first time conferences, especially when program leaders have felt isolated from one another. We see this impatience as an indication of the intense desire of Appalachian child advocates to be in touch with one another. This was reflected in the recommendations which emerged from the conference.

RECOMMENDATIONS

After nearly 3 days of intensive workshops, sharing information over breakfast, and caucusing after dinner, many conference participants remained for the concluding Friday morning session.

During the previous night, all workshop recorders, conference planners and the Friday morning panel, met to go over the recommendations for each workshop, combine those that overlapped, and organize them so that they were easily translatable, enabling participants to share them with colleagues back home who were unable to attend the conference.

They are presented here in such a way as to begin answering the three central questions around which the conference report was planned.

How Can we Begin to Meet the Needs of Appalachian Children?

1) We need to emphasize early intervention, so that services reach the child before age two. This includes maximizing community resources and such programs as WIC and EPSDT.

2)We need to concentrate on programming that will enhance the child's self-concept. Program staff must accept, respect, and appreciate the Appalachian heritage and build on it.

3) We cannot work with the child in isolation. The quality of the life of the child begins with the quality of life of their mothers. This necessitates working with young adults who later become parents. We must also stress working with the child in the context of his/her family.

How Can we Better Meet the Needs of Programs?

4) We need to encourage the stimulation of manpower development lest programs be doomed to failure due to lack of professionals with appropriate expertise.

5) We need more specificity in Administration. This includes more sophistication in cost accounting, and formal evaluation techniques and personnel management.

6) Programs must make full use of public information resources if they are to achieve future self-support.
7) We must develop parental awareness of their rights and skills and train professionals to accept and use the contribution of parents.
8) We should strengthen local boards to assist in the task of fund raising.
9) We must develop good information and referral systems to further the coordination of quality services.

How Can We Create More Effective Delivery Systems to More Adequately Meet the Needs of Programs and People?

10) We must find a means to continue sharing our expertise, experiences and knowledge.
11) Given the high level of frustration over the lack of information on legislation and regulations, we need to establish a state to state and program to program network for legislative information. We should begin to rely on our congressional representatives for this information.
12) There is an extreme dearth of statistics and an absence of a data base on the 13 state region in terms of volume of services, effects, and needs. We should support ARC's current activities to get such a data base and begin our own collecting of data at the state level. We must begin locating resources to help local programs build a data base as well.
13) ARC and other funding agencies should make public relations and information more of a priority.
14) Parent Advisory Councils should be mandated in legislation.
15) Linkages should be developed whereby parent involvement in preschool programs can be maintained throughout elementary and secondary school.
16) While we may be forced to look at a specific target or income group due to eligibility requirements in funding programs, we should maintain the provision of interdisciplinary and all-inclusive services.
17) We need sound information to substantiate the cost and the effectiveness of preventive services, as well as the dissolution of eligibility requirements.
18) The Federal government must make a commitment to children and this commitment must be a priority if we are to have more bicentennials . . .

Photo Credit: Jan W. Faul

MAY, 1974

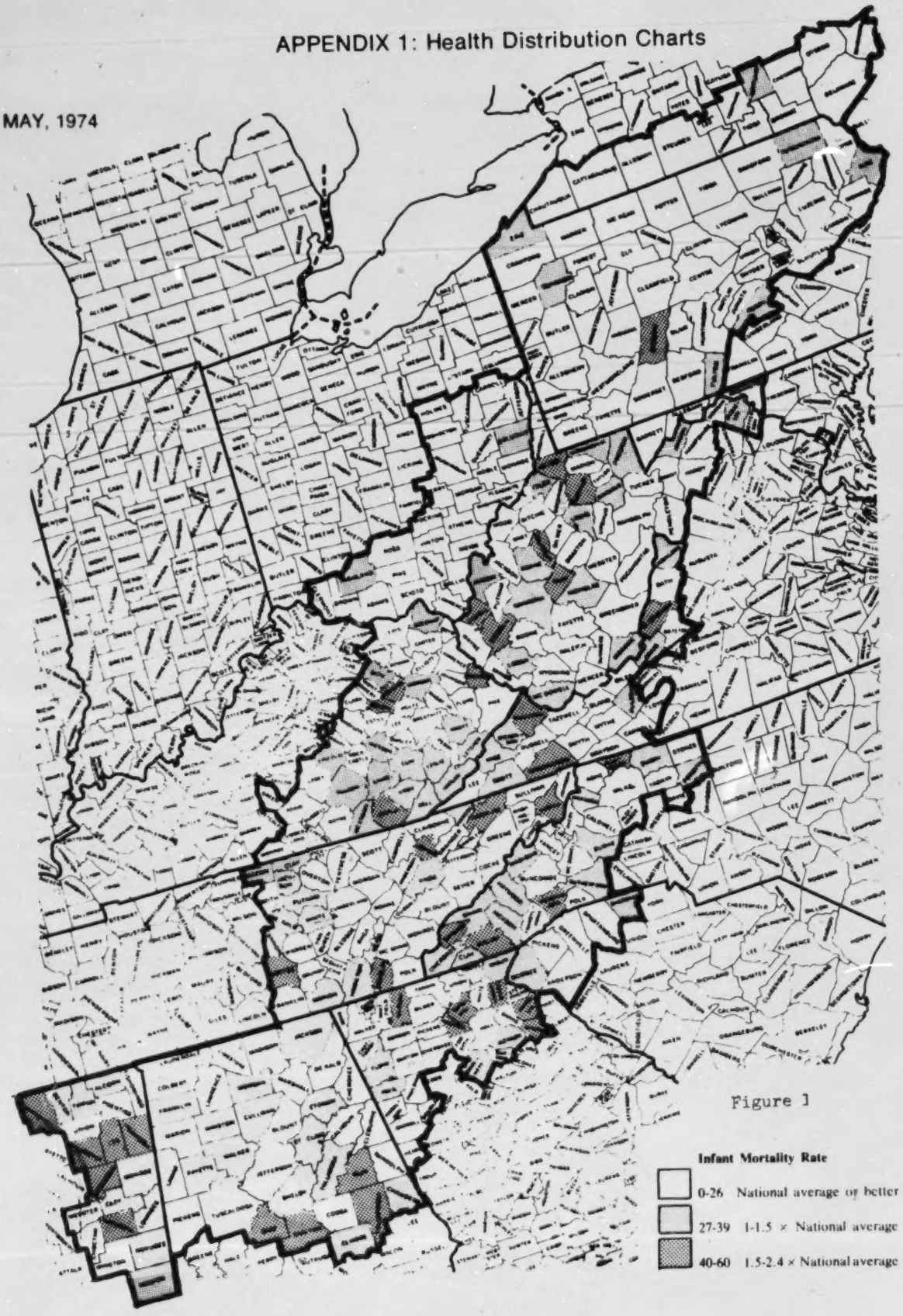


Figure 1

MAY, 1974

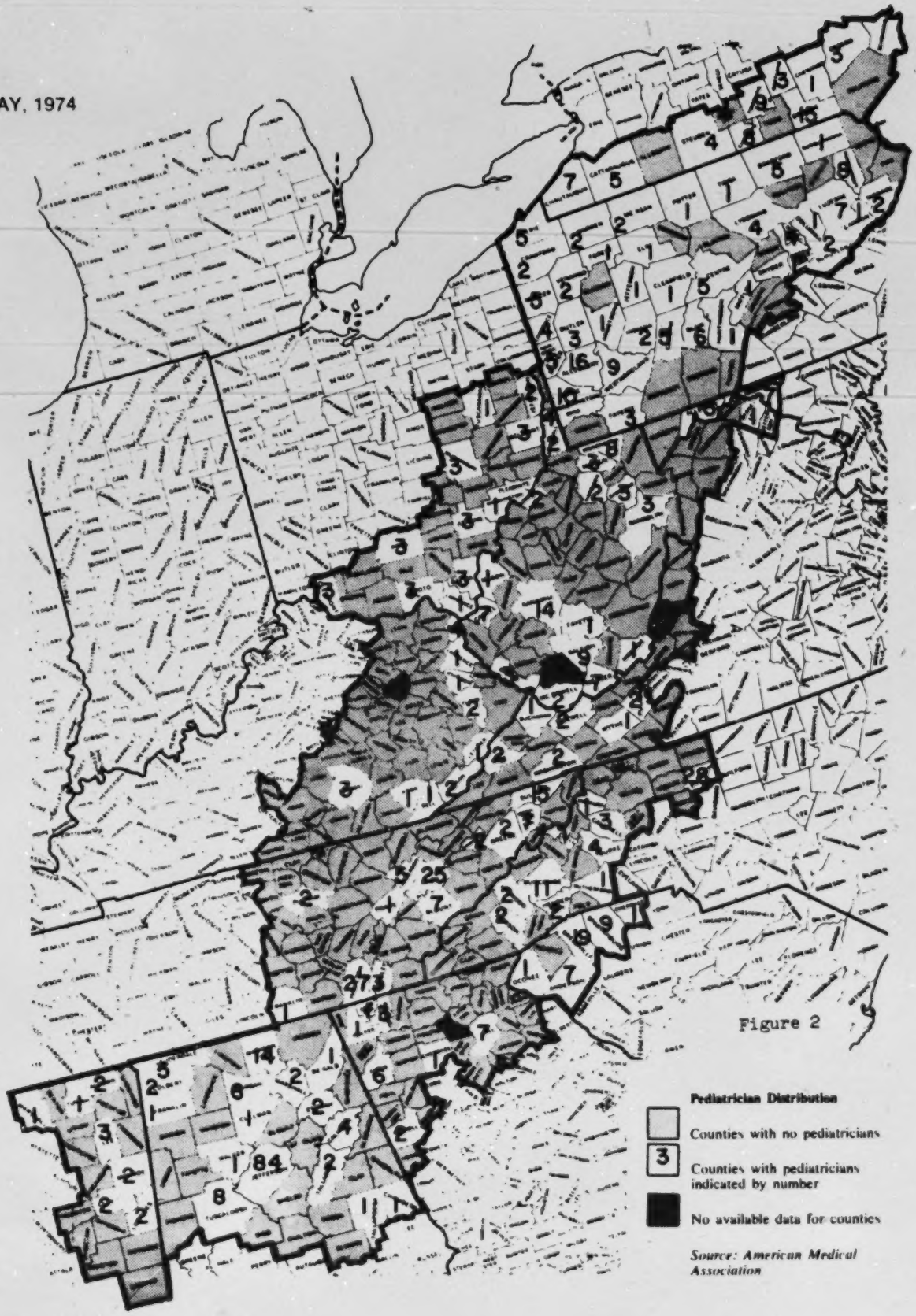


Figure 2

Critical Health Manpower Shortage Areas in Appalachia

Medically Underserved Areas

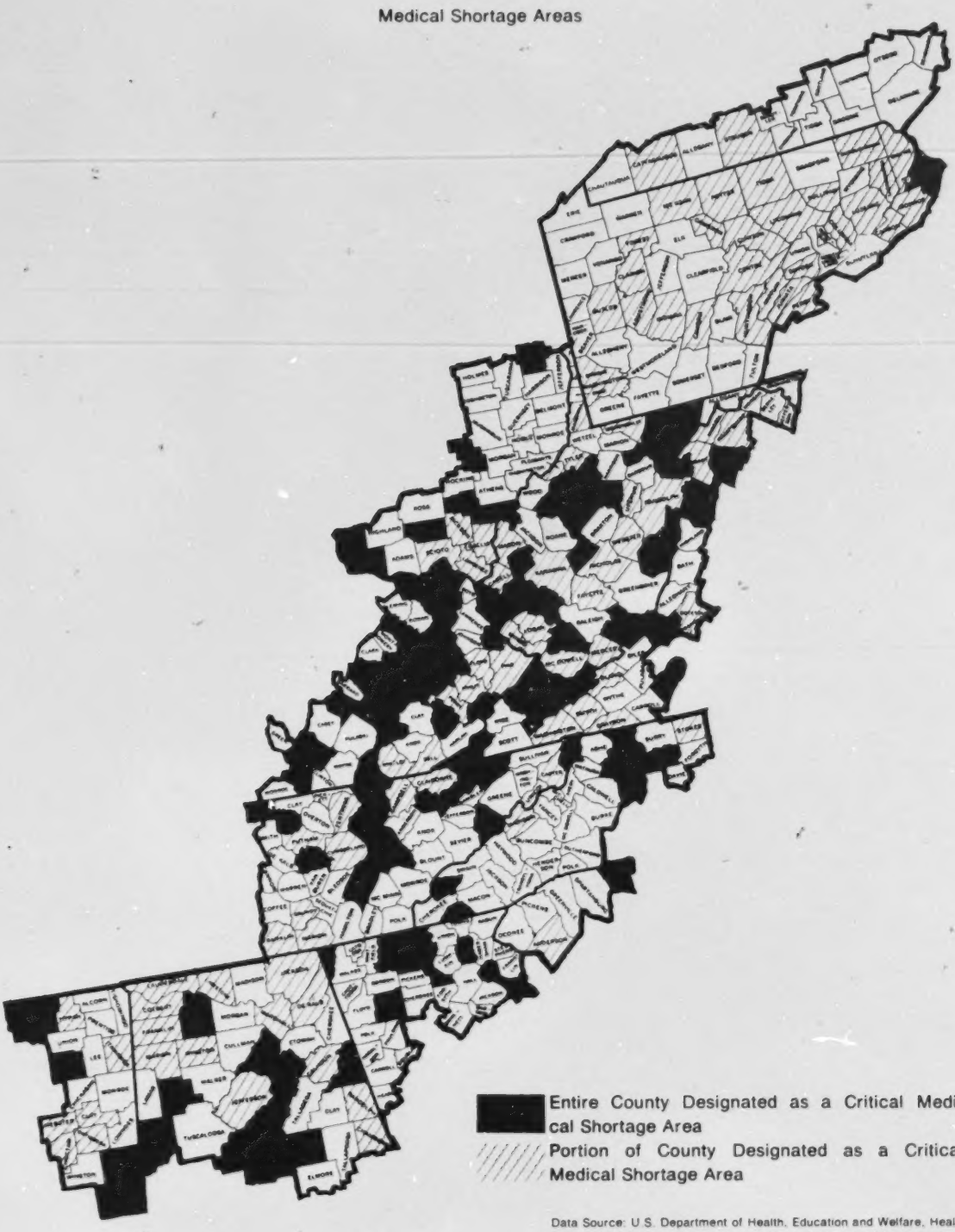
Entire County Designated as an Underserved Area

Portion of County Designated as Underserved Area

Data Source: Designation made by the Secretary of Health, Education and Welfare, pursuant to Section 1302(7) of the Public Health Service Act as enacted by the Health Maintenance Organization Act of 1973 (PL 93-222). Refer to *Federal Register*, Vol. 40, No. 170, September 2, 1975.

Critical Health Manpower Shortage Areas in Appalachia

Medical Shortage Areas



Entire County Designated as a Critical Medical Shortage Area

Portion of County Designated as a Critical Medical Shortage Area

Data Source: U.S. Department of Health, Education and Welfare, Health Resources Administration, Bureau of Health Manpower, Manpower Analysis Branch. *List of Critical Health Manpower Shortage Areas Designated under Section 329B, Public Health Service Act Updated as of January 31, 1976.* Report No. 76-89. January 31, 1976.

Critical Health Manpower Shortage Areas in Appalachia

Nurse Shortage Areas

County Designated as a Nurse Shortage Area

Designated under Section 836H of the Public Health Service Act

Data Source: U.S. Department of Health, Education and Welfare, Health Resources Administration, Bureau of Health Manpower, Manpower Analysis Branch, *Determination of Nursing Shortage Areas for the Purpose of Loan Repayment—A Summary Report*, Report No. 76-58A, January 15, 1976.

55

Critical Health Manpower Shortage Areas in Appalachia

Dental Shortage Areas

Entire County Designated as a Critical Dental Shortage Area

Portion of County Designated as a Critical Dental Shortage Area

Data Source: U.S. Department of Health, Education and Welfare, Health Resources Administration, Bureau of Health Manpower, Manpower Analysis Branch. *List of Critical Health Manpower Shortage Areas Designated under Section 329B, Public Health Service Act Updated as of January 31, 1976.* Report No. 76-89. January 31, 1976.

MARCH, 1975

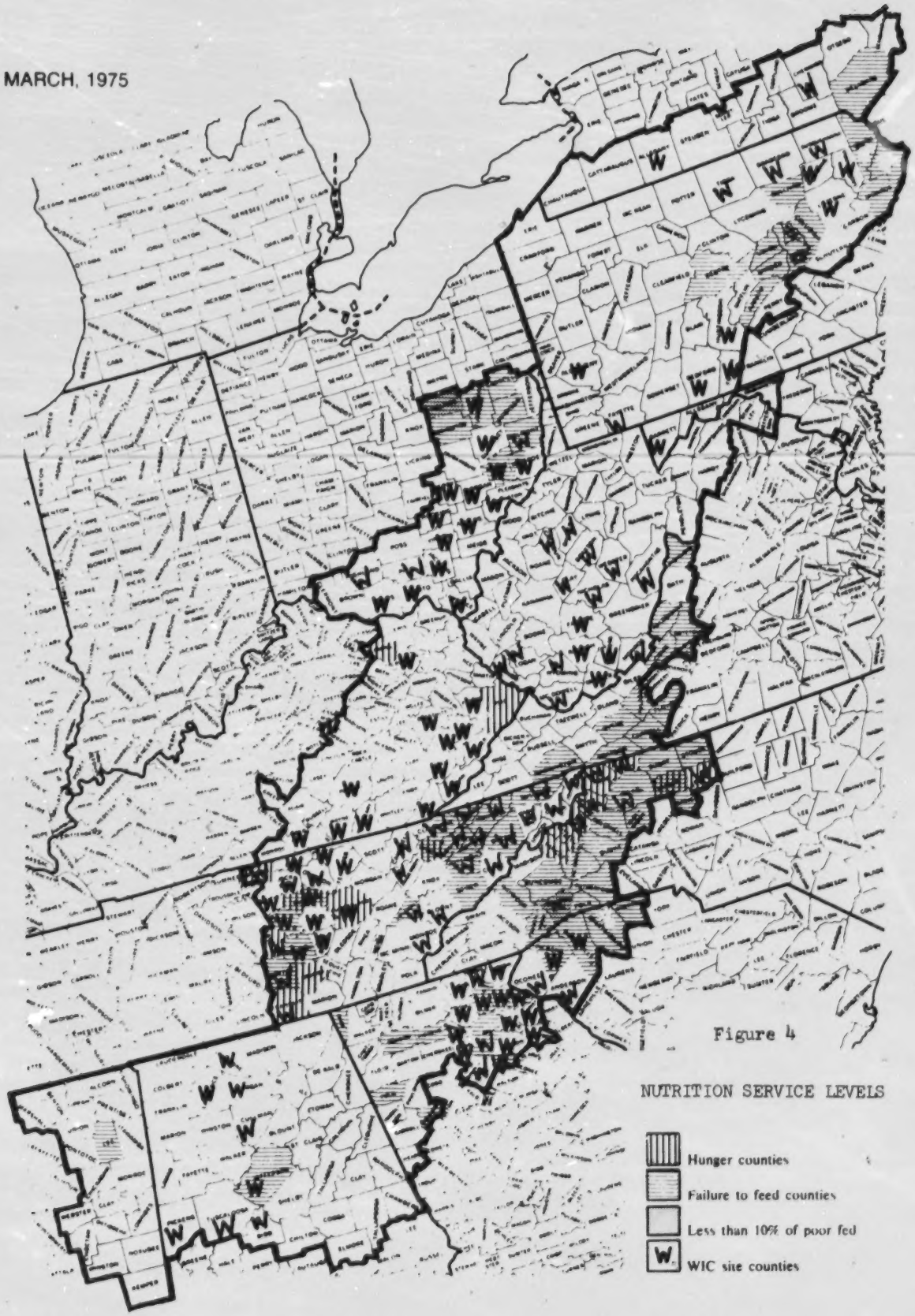


Figure 4

APPENDIX 2: FOUNDATION FUNDRAISING AND PROPOSAL WRITING

SPECIAL REPORT

FOUNDATION FUNDRAISING

Many persons are afraid of fundraising, mainly because they really don't know enough about it.

Raising funds for good community and religious causes is really a pleasure. It represents the use of personality, time, energy, and imagination for things that matter most--the care of fellow human beings.

Fundraising brings one in touch with other persons on a high level of relationship: we ask each other to give of our selves and our possessions for the sake of other persons, most of whom we may never know.

It has been very rare in my 36 years of fundraising to experience unhappiness. Not that every prospective donor always contributed or contributed to the degree I had hoped! Each experience is stimulating and thought-provoking. Many new friendships were acquired, and much good was done for those who needed help most.

I enjoy my relationships with government officials, corporation executives, and with those who support and conduct the affairs of foundations. I have found them reasonable and sympathetic and with no more hang-ups and short-comings than I have. As a matter of fact, several of them have become "most unforgetable persons" in my life.

There are men and women of good will everywhere and they will listen to every worthy appeal presented with conviction, courtesy, and clarity. And when they can, they give.

Our hope is that these pages of information and suggestions will be helpful to your cause. --Henry Endress, Executive Director.

FOUNDATIONS

Foundations are not temperamental money machines. They are persons. They are corporate bodies made up of people who have accumulated funds and who, for a variety of reasons, developed plans to make grants to worthwhile causes.

Foundations are made up of reasonable people who have drawn up a list of priorities and of objectives they wish to have fulfilled through their donations. Most times these objectives reflect the life purpose of the donors who set up the foundation. Their objectives can reflect their religious faith; ethnic relationships; business and professional loyalties; college loyalty; concerns for other people in general or in specific cause areas, and very often, their interest in perpetuating beyond their life span the good they did and hoped to continue to do.

Foundations are as sensitive as a person drawing up a last will and testament. They weigh all factors of their life, interest and relationships. They want to do

Source: Lutheran Resource Commission

what is right and good. They have their biases and eccentricities--just as those who come with appeals for funds.

Foundations receive many appeals and they give support to those causes and projects that have objectives that coincide with their own. They like proposals that are objective and yet express conviction and commitment. They are open to new ideas, in fact, are eager to venture with new ideas if presented by responsible persons. A foundation's horizon can be widened when the right presentation comes along.

Foundations don't like being put on the spot by emotional requests, sermonizing, or intimidation. They do not believe their integrity, credibility and reputation are at stake if they do not fund a particular project. Foundations receive many proposals and carefully choose those for funding that help them fulfill their purposes.

Foundations are regulated by government and, therefore, are sensitive to the ground rules.

Mailings of letters and proposals more or less at random may bring a result occasionally, but it is far better to do research and rather than use the buckshot approach, zero in on foundations whose purposes cover your project. There is a tendency to write to all the major foundations where, actually, the competition is high among professional grantsmen. While the "giants" might be interested in your project, it would be well to start with a study of foundations in your city and state.

Before preparing a proposal, prepare yourself.

When you prepare a proposal for a government agency you research legislation and program data and make use of it by reference in your text. When you prepare a proposal for a foundation you first search out foundations that would be interested in your project. You can do that in several ways:

(a) Contact Lutheran Resources Commission for data it may have or for advice in obtaining guidance.

(b) Do some research at the Foundation Center Library in New York or Washington, D.C., or at one of the eight (8) Regional Collections across the country.

(c) Talk with someone who has already dealt with the foundation.

(d) Confer with a foundation trustee if you or a friend know one.

(e) In your preliminary appointment with a foundation executive or officer, ask if he can lend you a copy of one or two successful proposals. See below for more information on a first visit.

Foundations will provide an opportunity for dialogue and presentation after they learn something about your project through a mutual friend, a brief letter, or a well-organized telephone call. This is the opportunity to learn more about the foundation and to make notes for preparation of a proposal specifically for this foundation. The proposal will go through foundation committee and board before a decision is made.

Foundations cannot say "yes" to every appeal no matter how worthy. They say "no" for funds reluctantly. Normally their requests for funds far exceeds the money available so they set up priorities and weigh each request. There is great competition for funds by many worthy causes.

Each foundation has its deadline dates for its committee work and the preparation of recommendations to its board which normally meets two or three times each year. If you miss one date, prepare well in advance for the next.

If you are turned down, don't be angry or quarrelsome. Normally there will be an opportunity to discuss why your proposal wasn't "top priority" in this round. With objectivity try to learn how you should revamp your project or proposal to reapply.

Say thank you for consideration, even if you are turned down. Build for the future. You may wish to apply again. Board members often serve on more than one board. Above all it is right to be courteous.

Letters to Foundations

For an appointment

Your letter for an appointment with the chief officer or executive should be brief:

Ask for the appointment to (a) learn more about the foundation's objectives and guidelines for proposals, and (b) state enough of your project to give them a fact and flavor of your proposal. Save the rest for your interview and written document.

Use official stationery or a typed-in heading. Type or write neatly.

When you obtain a date acknowledge it and be present on time.

Writing Proposals

Preliminary Suggestions

A covering letter on official stationery or a typed-in heading should accompany each proposal. It should serve as an introduction.

Proposals should not be inflations of the real project nor extended paragraphs or pages "viewing with alarm." Sermonizing and ecclesiastical language should be avoided. Government agencies cannot make grants for religious purposes; most corporations do not; many foundations do not. Stress concern for and service to meet human needs.

Some proposals might be used for submission to more than one foundation. It is far better, however, to tailor the document for each recipient in light of each foundation's interests and objectives--and requirements in a proposal.

Prospective donors are interested in purpose, know-how, and facts, not emotionalism. Some human interest can provide color, warmth, and meaning.

The LCR-W executive director has found this procedure most effective after selecting the foundations to be contacted and after getting all possible information about them:

(a) Write or telephone for an initial appointment.

(b) At the appointment listen carefully to the foundation officer's talk about the foundation's objectives, procedures, and requirements in proposals.

(c) Give a few highlights about your project--enough to get the foundation executive's reaction and suggestions. Be flexible in receiving suggestions and ideas. Don't argue or hard sell. Listen and learn and, if you believe there is some possibility--even if he'll just look it over to help--

(d) Go home and write up the proposal for that foundation, being faithful to the purpose of your project and, at the same time, if possible, meeting the requirements of the foundation. Tell the story simply, clearly, directly. Don't soft-soap or exaggerate. They are experienced experts at reading proposals.

(e) Test out your document on knowledgeable friends and get the approval of your supervisors--committee, chairman, or board.

(f) Then, as agreed, deliver it or mail it and have patience.

Note: There are professionals who can be engaged to write proposals and there are friends with experience who can "lend a hand." In either case make sure that you keep control of the document so that you are sure it truly tells the story of your project. There have been cases in which sponsors never see the document submitted nor would have recognized their project had they read it. Your board will hold final responsibility for the document, the project, and the fulfillment of its objectives by the donor.

Writing the Proposal

If you are asking for a grant for general operations, that must be made clear and this operation should be described.

If you are asking for funding for a particular project to be added to your operation make that clear.

If the project is new and innovative point that out. Foundations like to be known for creativity.

If you are asking for a one-time grant for the project point this out but indicate how you plan to finance thereafter.

As suggested above, it is best to find out from the prospective donor what is wanted in a written proposal before beginning. The following suggestions can be tailored toward that request.

(a) Begin by stating the purpose and objectives of your project and the dollar amount of the grant you are seeking. The foundation committee should

not have to read pages to discover that.

(b) Describe the surveyed need you wish to fulfill through the project. One or two brief human interest examples might be appropriate. Quotations of a few supporting statistics will help.

(c) Explain why your agency is the right one to meet this need. A brief quote from a consultant or public official could reinforce the point.

(d) Describe your proposed services, the standards by which they will be offered, and the fee structure, if any, --free services, part-pay, full fee. Note any purchase of service arrangements that might be negotiated with town, city, county, or state agencies.

(e) Describe staff, training, and supervision briefly.

(f) Report on other funding that has come or will come from church boards, parishes, other community organizations, etc., so that you answer the inevitable question: "What are these people doing to help themselves?" Include gifts in kind and donated services.

(g) Point up a few facts about your key board members and community representation. Also record the names of two or three consultants or advisors for the project.

(h) Note your plans for reevaluation of program and your plans to progress and evaluation reports that will be submitted to the foundation and others.

(i) Include an honest and realistic budget prepared by a professional accountant. You will be judged not by how small it is but how sound it is for a viable operation. (Amateurs forget items, and make budgets either too small or too large.)

(j) Express thanks for consideration and your conviction about the project and how the foundation will evaluate it.

For additional perspectives and suggestions you may wish to make use of the paperbound book "How to Write Successful Foundation Presentations" by Joseph Dermer. (See attached book list.)

Follow-up

In delivering the document you might ask when the foundation board can be expected to make announcement of its decisions. If the document is mailed, the question can be asked graciously in the covering letter or, better still, in a letter two or three weeks later. This second letter could also carry a fact or two (briefly!) on new progress.

If a grant is made, it will be for the purpose requested and, most often restated in the announcement letter from the foundation. A grant really is a feature of an agreement between donor and recipient. The recipient is under moral if not legal obligation to fulfill his part of the agreement--and to provide a concise report from time to time.

A letter of thanks should be mailed early from the chief officer or executive of the recipient agency. Such a letter and telephone call ought to ask for clarification as to which of you--donor or recipient--(or both) is to make public announcement of the grant. If the donor is in your general area, you might arrange press, radio, and TV coverage. When there is a ceremony or event for official opening of the operation, it is gracious to invite the foundation officials to participate.

Each act of good will builds a continuing relationship that can be very congenial and fruitful.

Proposals for Government Agencies

These proposals generally follow the pattern described above. But here too make sure you know what kind of written document is required. In most cases there are standard application forms that must be filled out first.

APPENDIX 3: STATE COORDINATORS FOR FEDERAL PROGRAMS

TITLE XX AGENCIES

ALABAMA
Jules Dimer
Commissioner
State Dept. of Pensions and Security
64 North Union Street
Montgomery, AL 36104

GEORGIA
T. M. Jim Parham
Acting Commissioner
Dept. of Human Resources
State Office Bldg.
Atlanta, GA 30334

KENTUCKY
C. Leslie Dawson
Secretary
Dept. for Human Resources
Capitol Bldg. Annex, Rm. 201
Frankfort, KY 20601

MARYLAND
Richard A. Batterton
Secretary
Dept. of Human Resources
1100 North Eutaw St.
Baltimore, MD 21201

MISSISSIPPI
Max M. Cole
Commissioner
St. Dept. of Public Welfare
P.O. Box 4321
Fondren Station
Jackson, MI 39216

NEW YORK
Steven Berger
Acting Commissioner
Dept. of Social Services
1450 Western Avenue
Albany, NY 12243

NORTH CAROLINA
David Flaherty
Secretary
Dept. of Human Resources
325 North Salisbury St.
Raleigh, NC 27611

OHIO
Raymond F. McKenna
Director
Ohio Dept. of Pub. Wel.
30 East Broad St.
St. Office Tower-32nd Fl.
Columbus, OH 43215

PENNSYLVANIA
Frank Beal
Secretary
Dept. of Pub. Wel.
Health & Welfare Bldg.
Harrisburg, PA 17120

SOUTH CAROLINA
Dr. R. Archie Ellis
Commissioner
Dept. of Social Serv.
P.O. Box 1520
Columbia, SC 29202

TENNESSEE
Horace Bass
Commissioner
St. Dept. of Hum. Serv.
204 St. Office Bldg.
Nashville, TN 37219

VIRGINIA
William Lukhard
Commissioner
Dept. of Welfare
8007 Discovery Dr.
Richmond, VA 23288

William Coopage, Dir.
VA Comm. for Visually Handicapped
3003 Parkwood Ave.
Richmond, VA 23221

WEST VIRGINIA
Thomas Tinder
Commissioner
1900 Washington St. East
Charleston, W. VA. 25305

EPSDT

Helen Wylie
Asst. Dir. for Health Serv.
Medical Serv. Admin.
Ala. Dept. of Pub. Health
2900 Fairland Dr.
Montgomery, AL 36111
(205) 277-2710

Wilma Cooper
Program Mgt. Officer, EPSDT
Division Benefits Payment
GA Dept. of Human Resources
St. Office Bldg.
Atlanta, GA 30334
(404) 894-4352

Luens Bishop
Section Supervisor Screening Service
Division for Medical Assistance
Dept. for Human Resources
U.S. 127 South
Frankfort, KY 40801
(502) 564-5472

Alexa Osborne
Medical Assistance Policy Administration
Dept. of Health & Mental Hygiene
301 West Preston St., 1st Floor
Baltimore, MD 21201
(301) 383-2658

Frank Edwards
Admin. Asst. Professional Serv.
MI Medicaid Commission
P.O. Box 5197
2906 North State St.
Jackson, MI 39216
(601) 354-7484

Elizabeth Hall
Sr. Medical Assistance Specialist
Div. of Medical Assistance
NY St. Dept. of Soc. Serv.
1450 Western Ave.
Albany, NY 12203
(518) 457-1009

Arthur Paradeos
Asst. Chief Recipient & Patient Services
P.O. BOx 2599
Dept. of Hum. Resources
325 N. Salisbury St.
Raleigh, NC 27602

Loyce Scott
Chief, Bureau of EPSDT
Div. of Medical Assistance
Ohio Dept. of Pub. Wel.
St. Office Tower, 34 Fl.
30 E. Broad St.
Columbus, OH 43215

Frank Clark
Chief, Div. of Soc. Programs
Office of Medical Prog.
Dept. of Pub. Wel.
Health & Welfare Bldg.
7th & Forester St.
Harrisburg, PA 17120
(215) 787-1170

Eugene Renaldi
Supervisor, Policy & Procedure Dev. Section
James Jollie
EPSDT Coord.
Medical Assistance Division
P.O. Box 1520
Columbia, SC 29202
(803) 758-7584

Robert Butler
Program Coord., Med. Div.
Dept. of Public Health
344 Cordell Hull Bldg.
Nashville, TN 36219
(615) 741-7221

William Sydnor
Mgt. Specialist
VA Medical Assist. Prog.
St. Dept. of Health
109 Governor St.
Richmond, VA 23219
(804) 730-7933

Rose Epting
EPSDT Coord.
Div. of Medical Care
St. Dept. of Welfare
1900 Washington St. East
Charleston, W. VA. 25305
(304) 345-8950

WIC

Emma Chiaccalos
Director
Nutrition Services
State of Alabama
Department of Public Health
State Office Building
Montgomery, Alabama 36104
(205) 832-6525

Frances Hanks
Child Health Unit
Georgia Department of Human Resources
47 Trinity Avenue
Atlanta, Georgia 30334
(404) 656-4467

Peggy S. Kidd
Administrator
Department of Human Resources
Bureau of Health Services
WIC Program
275 East Main Street
Frankfort, Kentucky 40801
(502) 564-4740

Carol Loomis
WIC Coordinator
Maryland State Department of Health and Mental Hygiene
301 West Preston Street
Baltimore, Maryland 21201
(301) 383-2838

Frank M. Wyrgul Jr. M.D.
Director
Health Services
Mississippi Department of Health
P.O. Box 1700
Jackson, Mississippi 39205
(601) 354-6660
ATTN: Truett Simmons
WIC Administrator
(601) 354-6655

John H. Brown, M.D.
Director
Bureau of Nutrition
New York State Department of Health
162 Washington Avenue
Albany, New York 12210
(518) 474-4374
ATTN: Sharon Smith
WIC Coordinator

Barbara Ann Hughes
Head
Nutrition Branch
Division of Health Services
State Board of Health
P.O. Box 2091
Raleigh, North Carolina 27602
(919) 829-2351

Joyce Kline, Ph.D.
Chief
Nutrition Division
Ohio Department of Health
450 East Town Street
P.O. Box 118
Columbus, Ohio 43216
(614) 466-4110

Henry Walkowiak
WIC Coordinator
Pennsylvania Department of Health
P.O. Box 90
Harrisburg, Pennsylvania 17120
(717) 783-1289
ATTN: Jeanne Shovlin
Nutritionist

Bonnie Hipkins
WIC Coordinator
South Carolina Department of Health and Environmental Control
2600 Bull Street
Columbia, South Carolina 29201
(803) 758-5485

H. Lee Fleshood, M.D.
Director
Nutrition Services
Tennessee Department of Public Health
405 Capitol Towers
Nashville, Tennessee 37219
(615) 741-3574

Liz Hitchcock
Division of Nutrition
Virginia Department of Health
8th Floor
James Madison Building
Richmond, Virginia 23219
(804) 770-7367

N. H. Dyer, M.D., M.P.H.
State Director of Health
State of West Virginia
1800 Washington Street East
Charleston, West Virginia 25305
(304) 348-2971
ATTN: Margaret Ferguson
(304) 348-2986

CHILD CARE FOOD PROGRAM, SCHOOL LUNCH & SUMMER FEEDING PROGRAMS

T. G. Smith, Coord.
Food Service & Local Accounting
St. Dept. of Education
410 St. Office Bldg.
Montgomery, AL 36104
(205) 832-3321

Josephine Martin, Admin.[1]
St. Dept. of Education
156 Trinity Ave., SW
Atlanta, GA 30303
(404) 656-2457

C. E. Bevins, Director
St. Dept. of Education
Capitol Plaza, 19th Fl.
Frankfort, KY 50801
(502) 564-3233

Ruthette Gumph
St. Dept. of Education
Friendship International Airport
P.O. Box 8717
Baltimore, MD 21240
(301) 796-5800

John H. Walker, Asst. Dir.
Admin. & Finance
St. Dept. of Education
Walter Sillers Off. Bldg.
P.O. Box 771
Jackson, MI 39205

Richard O. Reed, Chief
NY State Education Dept.
99 Washington Ave., 17th Fl.
Albany, NY 12210
(518) 474-1586 (S.L.)
474-3939 (S.F.)

Ralph Eaton
St. Dept. of Public Instruction
P.O. Box 12197
Cameron Village
Raleigh, NC 27605
(919) 829-7182

Robert Koon, Dir.[2]
St. Dept. of Education
65 S. Front St., Rm. 1009
Columbus, OH 43215
(614) 466-2945

Warren M. Vann, Jr. (S.L.)
Paula Gamber (CCFP)
PA St. Dept. of Education
Box 911
Harrisburg, PA 17126
(717) 787-1415

John L. Seurynck, Dir.[1]
St. Dept. of Education
305 Rutledge Bldg.
Columbia, SC 29201
(803) 758-2348

Lawrence Bartlett, Dir.[1]
St. Dept. of Education
C3-303 Cordell Hull Bldg.
Nashville, TN 37219
(615) 741-2547

John F. Miller, Sup.[3]
St. Dept. of Education
8th St. Office Bldg.
Richmond, VA 23216
(703) 786-2672

Ms. Faith Gravenmier
W. VA. Dept. of Education
1900 Washington St. East
Building 6, Rm. B-246
Charleston, W. VA. 25311
(304) 348-2708

1 For Child Care Food and Summer Feeding Programs, write to:
Southeast Regional Office
William F. Griffith, Director
FNS, USDA
1100 Spring Street, N.W.
Atlanta, Georgia 30309
(404) 526-5811

2 For Child Care Food and Summer Feeding Programs, write to:
Midwest Regional Office
Robert Nelson, Director
FNS, USDA
536 South Clark St.
Chicago, Illinois 60605
(312) 353-6673

3 For Child Care Food and Summer Feeding Programs, write to:
Mid-Atlantic Regional Office
David Alspach, Director
FNS, USDA
729 Alexander Rd.
Princeton, NJ 08540
(609) 452-1212

APPENDIX 4: HELPFUL PUBLICATIONS

I Available from the Appalachian Regional Commission

The Annual Report of the Appalachian Regional Commission.
Appalachia, a bi-monthly magazine.

Kirschner Associates, Inc. Assessment of the Health and Child Development Program of the Appalachian Regional Commission. July, 1975.

Child Development, A Report by the Appalachian States August, 1975

Health and Child Development Subcommittee, Final Report, Discussion Draft II (September 20, 1974)

ABT Associates
A Cost Analysis and Management Assessment of Five Child Development Centers That Receive Appalachian Regional Commission Financial Support 1973

The Urban Institute Health and Child Development Program: Analysis of Evaluation Prerequisites, Volume I, 1976

II Available from Federal Agencies

From Office of Manpower
DHEW
Washington, D.C.

- Ceta and HEW Programs

From Medical Services Administration
DHEW
Washington, D.C.

- Health Screening and Treatment for Children

- A Guide to Screening

(Ask for updates of other materials on EPSDT.)

III Available from private organizations in Washington, D.C.

From National Council of Organizations for Children and Youth
1910 K Street, N.W.
Washington, D.C. 20006

- America's Children 1976 A factbook about children in poverty, child health problems, changes in American family structure, child care needs and federal programs serving children. $4.00

· Congress and Federal Agencies: 1976 Directory for Child Advocates. A directory which helps the reader locate key personnel in congressional committees and Federal agencies with responsibility for major programs affecting children and youth. $1.25

(2) From The Children's Foundation
1028 Connecticut Avenue, N.W.
Washington, D.C. 20036

· Working for Women and Children First: The WIC Organizing Guide
A comprehensive guide to getting a WIC program started in your community. $1.50

· 1975 Revised Directory of Special Supplemental Food Programs In Women, Infants, and Children "WIC" June 1975. $1.25

Ask for their updated materials on the USDA Child Care Food Program

(3) From The National Center for Community Action
1711 Connecticut Avenue, N.W.
Washington, D.C. 20009

· "The Budget of the United States Government Fiscal Year 1977: Impact on Programs Affecting the Poor." The National Center Reporter Volume 3, Number 3, March 1976.

Ask for their other materials on funding for human service programs.

(4) From Day Care and Child Development Council
1012 14th Street, N.W.
Washington, D.C. 20005

· Harrell, James. Rural Child Care: A Summary of the Issues, 1974 .75¢

· Levine, James. Hustling Resources for Day Care .75¢

· Perreault, Joseph Management Problems in Providing Transportation Services for Rural Child Development .75¢

· Georgia Appalachian Outreach Project. Principles of Home Visiting $3.00

IV Available from Kentucky Youth Research Center
P. O. Box 713
Frankfort, Ky. 41314

· Perreault, Joseph and Hartzler, Rod. Background Paper for Consideration of Kentucky's Options in Planning and Use of ARC Child Development Funds. March 1976

· Fitzpatrick, Ruth. Who Will Call the Tune in Appalachia? An Inquiry into Industries' and Unions' Interest in Child Care for Eastern Kentucky. 1976

(Prices may be subject to change)

APPENDIX 5: CONFERENCE AGENDA

"THE STATE OF THE CHILD IN APPALACHIA CONFERENCE"

Program
Wednesday, April 28, 1976 A.M.
Howard Johnson Motel
Knoxville, Tenn.

II. KEYNOTE ADDRESS

Dr. Cratis Williams

IIA. NUTRITION

A review of the current findings on the effect of nutrition, identification of barriers that prevent application of knowledge, strategies for improving nutrition especially at critical states of development.

Presenter: Dr. William O. Castor
Chairperson: Rod Hartzler

IIB. MEDICAL AND DENTAL SERVICES

An examination of the medical and dental needs of children in rural areas, creative ways of effectively utilizing our scarce resources to better meet the needs.

Presenters: Dr. Jack Basman
Grant Leidy
Dawn C. Bolstad
Chairperson: Edna Tate

IIC. MENTAL HEALTH

Consideration of the mental health needs of children, programs for prevention of problems, early diagnosis and treatment.

Presenters: Dr. Gregory Cully
Dr. Harold McPheeters
Chad Jackson
Chairperson: Dr. Harold McPheeters

IID. PERI-NATAL PROGRAMS

Emphasis on meeting needs at this very critical state in child development through a variety of programs.

Presenters: Dr. Richard Stuntz
Dr. Thomas Lester
Chairperson: Jean Smith

C7

IIE. PARENTING

Recognizing that the family is the most powerful and important influence in a child's development, some demonstrations have been directed to the preparation of young people for this role, others have sought to provide help to those who have young children. This session will examine some of these and the potential for the future.

Presenters: Al James
Dr. Ralph Wetzel
Barbara Beville
Chairperson: Al James

IIF. PARENT INVOLVEMENT

This session looks at ways in which parents are encouraged and helped to develop skills to participate in the decision-making process in their communities around programs that effect their children.

Presenters: Dorothy Sampson
Annette Richie
Gary Wilson
Crystal Kuykendall
Chairperson: Nancy Travis

IIG. COMMUNITY DEVELOPMENT

A discussion of the process of working with a wide range of citizens in planning for ways to meet their own goals for their communities and their families.

Presenters: Carroll Parker
Ben Poage
Helen Taylor
Mike McGuire
Chairperson: Carroll Parker

IIH. CHILD ABUSE AND NEGLECT

A look at these problems which are prevalent nationwide as they are manifested in rural areas with possibilities for prevention and treatment.

Presenters: Bill Chamberlain
Clara L. Johnson
Juanita Walker

"THE STATE OF THE CHILD IN APPALACHIA CONFERENCE"

Program
Wednesday, April 28, 1976 P.M.

III. GENERAL SESSION

"PUBLIC AND PRIVATE ORGANIZATIONS NOW WORKING IN APPALACHIA"

Brief presentations from a wide variety of agencies. The purpose of this session is to identify resources with the hope that ways can be found for programs to complement and supplement each other and to expand the possibility for replication of successful program models. Examples of organizations are: religious groups, settlement schools, cooperative extensions, educational institutions, state and federal programs, etc.

Presenters: Sophia Harris
Rev. Don Stillwell
Lucy Biggs
Polly Koehler
Crystal Kuykendall
Neal Buchanan
Ben Poage

Chairperson: Barbara Lou Clay

"THE STATE OF THE CHILD IN APPALACHIA CONFERENCE"

Program
Thursday, April 29, 1976 A.M.

IVA. INFANT CARE

Several approaches to meeting the needs of infants when they must be out of the home for part of the twenty-four hour day.

Presenters: Mary Jane Bevins
Runelle Steadman
Anne Willis
Reba Southwell
Chairperson: Willie Ruth Thompson

IVB. DAY CARE CENTERS

The Appalachian demonstration provides a number of delivery system models and sponsorships. Several alternatives including public schools will be presented.

Presenters: Calvin Thomas
Dinah Burns
Patricia Peck
Betty Carnes
Chairperson: Betty Carnes

IVC. FAMILY DAY CARE

Several models of family day care systems will be discussed with an emphasis on implementation in rural areas.

Presenters: Margaret Hale
Sue Corley
Ernest Ewing
Andrea Morrison
Barbara Barry
Chairperson: Thomas Harris

IVD. TRAINING

A major key to successful programs is having a staff able to do their jobs well. This session looks at several approaches to making ongoing in-service training available.

Presenters: Desmon Tarter
Nancy Edwards
Saundra Ground

IVE. RELATING THE CURRICULUM TO THE CHILD'S LIFE EXPERIENCES

There are many theories and philosophies of curriculum for very young children. A number of Appalachian programs attempt to give children a sense of pride in their own heritage and at the same time to expand their experiences. Several approaches will be discussed.

Presenters: Lynn Champion
Michelle Stewart
Roy Alford
Chairperson: Helen Stealey

IVF. TITLE XX

How the services are being handled, the delivery and accountability and how some folks are making it work for children.

Presenters: Sigmund Lipsitz
Eileen Wolff
Candice Mueller

IVG. APPALACHIAN REGIONAL COMMISSION, APPALACHIAN REGIONAL DEVELOPMENT ACT

A description of the intent, philosophy, and impact of the Appalachian Regional Commission in the area of human services (a new four year ACT has recently been passed by Congress). The contribution of a planning process and demonstration programs will be discussed.

Presenters: John Himelrick, Sr.
Rod Hartzler
Bob Decker
Steve Johnson
Chairperson: Rod Hartzler

IVH. EARLY PERIODIC SCREENING AND DIAGNOSIS TREATMENT PROGRAM

Discussion will focus on implementation of this program in Appalachia. What are the problems? What are some delivery systems that are working well? How is available health manpower being used? How can we help make the system work?

Presenters: Richard Farr
Paul Tenan
Pat Viles
Chapin Wilson
Bea Moore
Chairperson: Pat Viles

IVI. PUBLIC INFORMATION

Developing an effective public information campaign dealing with human services especially at the single center level is so important. How can the program be publicized and interpreted to the community?

Presenters: Dr. Beatrice Carman
June Varner
Chairperson: Joseph B. Wilson

IVJ. HOME BASED CHILD DEVELOPMENT

In some Appalachian areas that are isolated and transportation is lacking, services are taken to the home -- these services may be in child development, health, nutrition, homemaking skills. In some programs these are also periodic opportunities for group activities. Several strategies will be presented.

Presenters: Dr. Dorothy Washington
Carrie Thomas
Adinah Robertson
Corliss Ann Keown
Jenny Lee Moore
Mary Jo Ann Richards
Jo Zingg
Pat Griffin
Chairperson: Jo Zingg

IVK. NUTRITION

A discussion of several strategies for improving nutrition for Appalachian families with an emphasis on such critical periods as pre-natal, infancy and childhood.

Presenters: Bryan Fluck
Dorothy McMabb
Susan Graves
Jane Mapp
Chairperson: Virginia Gemmell

IVL. INFORMATION AND REFERRAL

Development of child care councils can provide a network that links potential users of service to services available. Councils can recruit and identify services, document needs, carry out public education for consumers in choosing services for their children, encourage advocacy on behalf of children and families. Such a network brings together public and private groups and can serve all families regardless of income.

Presenters: Sandy Lyons
Sandy Lambert
Barbara Barry
Polly Koehler
Chairperson: Sharon Railey

IVM. EARLY IDENTIFICATION OF LEARNING AND DEVELOPMENTAL DISABILITIES

How can these problems be identified and corrected? How can we provide needed services and yet avoid the danger of permanent label which adversely effects the child's concept of himself and the way in which the community views him. Several approaches will be discussed.

Presenters: Dr. Charles Orlando
April Beavers
Dr. James Spalding
Virgelia Meek
Judy Pearson
Chairperson: Dr. Charles Orlando

IVN. SCHOOL AGE PARENTS

National statistics tell us that more and more babies are being born to young people who have not completed their schooling and who have not acquired the skills needed to be self-sufficient. A number of Appalachian Regional Commission demonstrations have addressed themselves to helping young people continue their education and to develop the life skills to help them meet their responsibilities. Various approaches will be looked at.

Presenters: Bessie King Jackson
Abbie Chapman
Patricia Byler
Chairperson: Barbara Lou Clay

IVO. PROGRAM ADMINISTRATION

To be focused at the level of a single center director or administrator of a small program. Example of topics to be discussed are budget building, planning, staff supervision, involving the parents, working with a board of directors, in-service training and other administrative issues.

Presenters: Barbara Beville
Mike Harter
Norma Gray
Francis Cummings
Sara Farmer
Chairperson: Dave Sweitzer

IVP. USDA NATIONAL SCHOOL LUNCH AT

A discussion of the provision of the revised Act including administration, eligibility criteria, reimbursement policy, commodities and non-food assistance programs. Clarification of regulations in regard to family day care.

Presenters: Don Wright
Elizabeth Shiver
Chairpersons: Don Wright
Elizabeth Shiver

IVQ. THE IMPACT OF THE NEW FEDERALISM ON HUMAN RESOURCE PLANNING AND PROGRAMS

Focusing upon the impact of a variety of new programs such as CETA and general revenue sharing that are emerging at both the state and federal levels and how they can be used in conjunction with other funding sources.

Presenters: Joe Perreault
Linda Gayheart
Chairperson: Joe Perreault

IVR. RESOURCE DEVELOPMENT

Presenters: Thomas McClure
Dix Griesemer
Thomas Murray
Joe Perreault
Chairpersons: Thomas McClure
Dix Griesemer

"THE STATE OF THE CHILD IN APPALACHIA CONFERENCE"

Program
Friday, April 30, 1976 A.M.

V. CONFERENCE SUMMARY, RECOMMENDATIONS, AND FUTURE DIRECTIONS

All of the workshop sessions and informal evening meetings will be encouraged to bring in recommendations. A committee will meet Thursday evening to coordinate and consolidate these to prevent duplication.

Presenters: Neal Buchanan
Nancy Travis
Bessie King Jackson
Mike Harter
Jim Kennelly
Chairperson: Nancy Travis

APPENDIX 6: CONFERENCE PLANNING COMMITTEE *

Nancy Travis, Chairperson

Barbara Lou Clay, West Virginia

Virginia Gemmell, Washington, D.C.

Rod Hartzler, Kentucky

Al James, Save the Children Federation

Tom McClure, Resource Mobilization Center

Joseph Perreault, Kentucky

Sharon Railey, New York

June Rogers, New York

Jean Smith, Tennessee

Harold Springer, Maryland

Helen Stealey, West Virginia

Special thanks are due to the Appalachian Office of Save the Children Federation, who coordinated the conference and to Elaine Daneloff, student intern from Beloit College who looked after the many day-to-day details involved in running a conference.

*This represents the group of planners who were able to come consistently to meetings. At various times other representatives of Appalachian Child Development projects participated in planning.

APPENDIX 7: CONFERENCE ATTENDANCE BY STATE

"THE STATE OF THE CHILD IN APPALACHIA CONFERENCE"

Alabama	6
Georgia	48
Kentucky	63
Maryland	28
Mississippi	8
New York	20
North Carolina	15
Ohio	18
Pennsylvania	9
South Carolina	4
Tennessee	129
Virginia	3
Washington, D.C.	13
West Virginia	61
Arizona	1
California	1
Colorado	1
New Mexico	1
South Dakota	1
Texas	1
Total Conference attendance	431

APPENDIX 8: CONFERENCE PARTICIPANTS

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